The Journal

of the

Louisiana State Medical Society

$4.00 Per Annum, 35c Per Copy
Vol. 112, No. 6

JUNE, 1960

Published Monthly
1430 Tulane Avenue, New Orleans 12, La.

Diverticulitis: Indications For Surgery*

• The morbidity of the surgical treatment of diverticulitis remains high. It can be reduced, first, by avoiding those operative procedures that have proved unsatisfactory for the surgical treatment of this disease, and second, by advising patients with persistent or recurrent diverticulitis to be operated on before perforation, a fistula or complete obstruction develops. This can be done while still maintaining the present low case fatality rate associated with the surgical treatment of this disease.

BENTLEY P. COLCOCK, M. D. †
Boston, Mass.

DIVERTICULITIS is a fascinating disease because it manifests itself in so many different ways. A patient with diverticulitis may have only an occasional episode of mild abdominal distress, or he may have all the signs and symptoms of a carcinoma of the colon. He may complain of a persistent soreness in the lower part of the abdomen or he may present the picture of acute appendicitis. He may have no gastrointestinal symptoms and complain only of dysuria and pain in his bladder.

Diverticulitis is also a treacherous disease. A moderate degree of abdominal pain and distention may suddenly develop into acute large bowel obstruction. If one of the inflamed diverticula perforates, peritonitis results. This immediately produces a very dangerous situation in an obese, elderly patient. Even the patient whose only symptom is the passage of gas from the urethra has a serious complication of diverticulitis. It will be many weeks or months before any one of these patients is well again.

The mortality rate for the surgical treatment of diverticulitis just twenty-five years ago was as high as 50 per cent. Today it is less than 5 per cent and the mortality rate at this clinic for the last ten years was 1.5 per cent. We have had no deaths following surgery for diverticulitis during the last seven years. The greatest single factor responsible for this remarkable reduction in mortality rate has been the routine use of a staged operative attack for patients with the complications of this disease.

Surgical Treatment

Operation is required when the colon becomes obstructed, perforates or forms a fistula into the bladder or vagina. If

* Presented at the Twenty-third Annual Meeting of the New Orleans Graduate Medical Assembly, March 7-9, 1960.

† Department of Surgery, The Lahey Clinic, Boston, Massachusetts.

complete obstruction or a perforation is present, the need for surgery is urgent. Apart from drainage of a large abscess, the only operative procedure that should be done is a proximal colostomy. Later, the patient will need a resection of the diseased colon and closure of his colostomy. The colostomy is made in the proximal part of the transverse colon (Fig. 1) so as to permit mobilization of the splenic flexure at the time of the subsequent resection. If the inflammatory reaction surrounding the perforation or the fistula is extensive, it will take from four to six months to subside. The sigmoid can be resected more easily and the risk of further complications reduced if the patient is advised to wait this length of time. If the inflammatory reaction has completely subsided, the colostomy may be closed at the time of the resection. This should only be done, however, when the surgeon is entirely satisfied with the integrity of his anastomosis. If a defect is present and leakage occurs, the anastomosis will heal without incident if a proximal colostomy is present; without the colostomy, it may lead to an abscess and a fistula.

Differentiation of Diverticulitis and Carcinoma

It is quite typical of diverticulitis that even the treatment of choice cannot be applied routinely. Carcinoma of the sigmoid must be ruled out in each of these patients. In practically all patients with diverticulitis the segment of colon involved is the sigmoid. The sigmoid is also the commonest site for carcinoma of the colon. Both conditions occur in the same age group and the symptoms of each may be identical. If carcinoma cannot be excluded, the lesion must be resected in two to three weeks following the colostomy, rather than after four to six months. Even when conditions permit a primary resection of the sigmoid, the operative procedures for these two lesions differ considerably. To subject a patient with diverticulitis to an extensive cancer operation is unnecessary, and is associated with an increased morbidity and mortality rate because of the inflammatory reaction present. On the other hand, if carcinoma is present, a conservative resection may forfeit the patient's only chance for cure.

Proctoscopic examination rarely per-

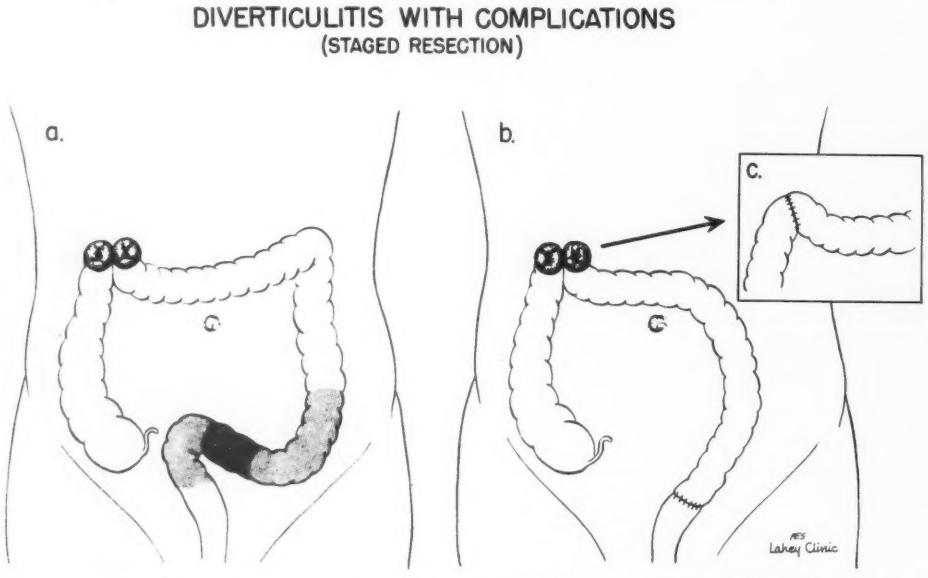

Figure 1. **a**, Proximal colostomy established in transverse colon; bowel completely divided. **b**, Resection of diseased bowel with anastomosis is carried out four to six months later. **c**, The colostomy is closed by end-to-end anastomosis and the bowel restored to the peritoneal cavity.

mits differentiation of these two conditions. In most instances reliance must be placed on the barium enema study. Unfortunately, in 15 to 20 per cent of patients the roentgenologist cannot distinguish with certainty between carcinoma and diverticulitis of the sigmoid. In another 5 to 10 per cent, the barium enema simply reveals obstruction of the colon which could be due to either carcinoma or diverticulitis. Multiple perforations almost certainly are the result of diverticulitis (Fig. 2). When the typical lipping of a carcinoma of the sigmoid is present, the diagnosis is rarely in doubt (Fig. 3). If the barium also fills the bladder because of a fistula between the colon and bladder, the patient is much more likely to have diverticulitis than cancer (Fig. 4). On the other hand, the barium enema examination at times will deceive even an experienced diagnostician. Since the two lesions involve the same area in the colon, it is not strange that occasionally both may be present (Fig. 5).

Even at operation it may still be impossible to distinguish between these two conditions. Under these circumstances

Figure 2. This patient has remained well following a three stage resection of the descending colon and sigmoid.

Figure 3. Typical appearance of a carcinoma of the bowel on the spot film.

the type of resection to be carried out presents a real problem to the surgeon. A few years ago in an effort to obtain some additional help in such situations we [2] reviewed in detail the histories of 50 patients with diverticulitis who came to surgery, and 50 patients with carcinoma of the sigmoid. Despite many similarities, we noted a few points which may be of help in an equivocal case. Abdominal pain was found to be three times as frequent in patients with diverticulitis as in those who had carcinoma. Gross rectal bleeding, on the other hand, was three times more common in patients with carcinoma. The duration of symptoms averaged 40.2 months in patients with diverticulitis and only 8.5 months in patients with carcinoma (Table 1).

Morbidity and Mortality

The indications for surgery in complicated diverticulitis are obvious. It is equally obvious that, in spite of the reduction in mortality rate, the morbidity associated with the surgical treatment of diverticulitis remains high. A patient

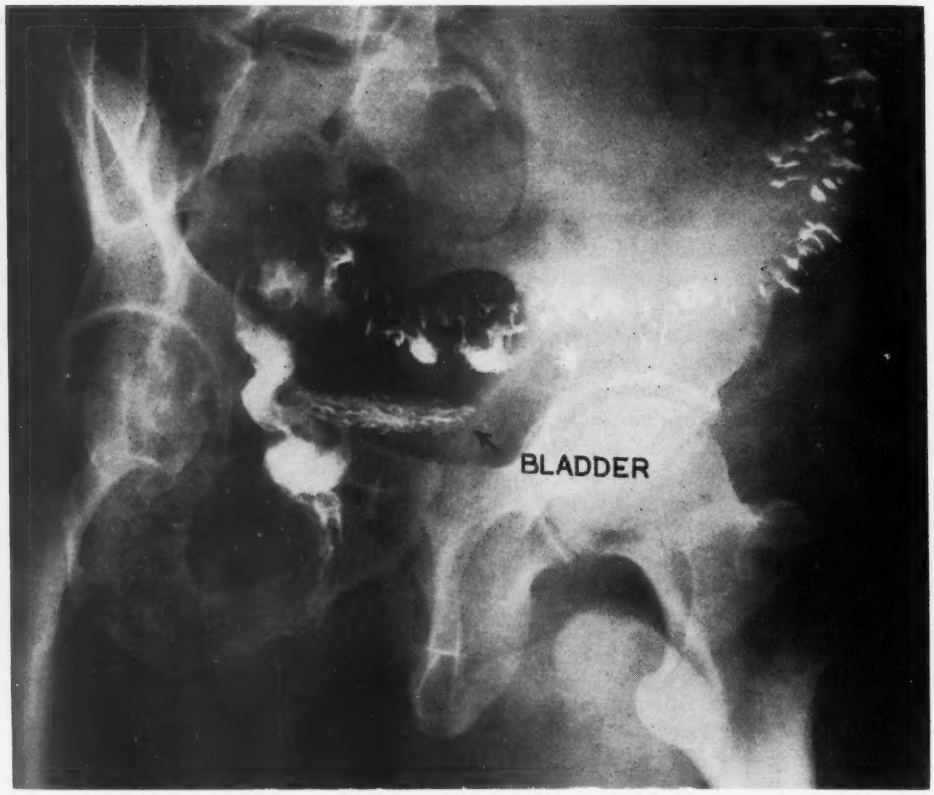

Figure 4. On barium enema examination the barium passed rapidly from the colon into the bladder through the fistula.

Figure 5. The abnormal appearance of the sigmoid is due to diverticulitis. In the center of this area is a large malignant polyp.

TABLE 1
DIVERTICULITIS AND CARCINOMA OF THE COLON

	Diverticulitis	Carcinoma
Age	53.5 years	61.5 years
Sex	62% males	46% males
Abdominal pain	74%	26%
Abdominal colic	80%	38%
Rectal bleeding	22%	64%
Duration and symptoms	40.2 months	8.5 months
Nausea and vomiting	higher	
Chills and fever		

with obstruction, a perforation or a fistula will spend two weeks or more in the hospital at his initial hospitalization. He then goes home for a period of four to six months with a colostomy. During this time he may or may not return to work. He must then return for a major operative procedure. Finally, the colostomy must be closed, either at this time or at a third admission. The total cost in hospital and medical care is tremendous, and could lead to a financial crisis in many families.

One way in which this morbidity can be reduced is by avoiding operative procedures that are known to be unsatisfactory for the surgical treatment of this disease. Incision and drainage of an abscess due to a perforation of the colon, without a colostomy, usually results in a permanent fistula. Suture of a perforation or excision of an existing fistula is rarely successful. Closure of a colostomy without a subsequent resection is likely to result in recurrence of symptoms and the development of another complication. Thirty per cent of the patients on whom we have operated during the last ten years gave a history of one or more of these operative procedures. Some patients had as many as seven or eight operations, and they still required a colostomy followed by resection and closure of the colostomy before a cure was obtained.

Our best opportunity for reducing the morbidity rate for the surgical treatment of this disease is to operate on patients with intractable diverticulitis before these serious complications occur. To a considerable degree, we can identify the patient in whom obstruction, perforation or a fistula is likely to occur. He is the patient with diverticulitis who is under 50 years of age; whose attacks of diverticulitis are increasing in frequency or in severity; who shows an increasing degree of spasm or narrowing on barium enema study; the patient who begins to have dysuria or pain in the bladder with his attacks of diverticulitis. If these patients are operated on before complications occur, resection of their diseased colon can be carried out in one operative procedure. They rarely spend more than two weeks in the hospital, and their disease is cured. Finally, the risk of attributing the symptoms of a carcinoma to an old, recurrent diverticulitis is eliminated.

Earlier operation for patients with divertculitis can be justified *only* if it does not increase the mortality rate. During the last ten years [1] we have operated on 131 patients for diverticulitis; two deaths occurred, a mortality rate of 1.5 per cent. Both patients had a proximal colostomy for a perforation of the sigmoid. Because carcinoma could not be ruled out, each had a resection of the colon three weeks later. In both cases, the resection was carried out in an infected field, and generalized peritonitis developed. One patient died from coronary occlusion on his twenty-first postoperative day; the other patient died six months later from prolonged sepsis. During the last seven years 102 patients in this group were operated on with no deaths. It is significant that 69 of these patients had a one stage primary resection [1] (Table 2).

TABLE 2
MORTALITY

	Number of Patients	Deaths	
		Number	Per Cent
Total	131	2	1.5
Last 7 years	102	0	0
One stage resection	69	0	0

Summary

Patients with diverticulitis who have complete obstruction, a perforation, or a fistula into the bladder or vagina, must be operated on. The mortality rate for the surgical treatment of even these seriously ill patients is now less than 2 per cent. This is largely due to the proven safety of a staged operative attack. Unfortunately, the morbidity rate associated with the surgical treatment of diverticulitis remains high. It can be improved by avoiding operative procedures which are unsatisfactory for the surgical treatment of this disease. The best opportunity to reduce the morbidity rate lies in earlier operative for patients with intractable diverticulitis. If surgery is advised for selected patients with persistent or recurrent diverticulitis before a complication develops, they can be cured by a one stage operative procedures with no increase in the mortality rate.

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1. Colcock, B. P.: Surgical management of complicated diverticulitis. New England J. Med. 259:570 (Sept. 18) 1958.

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Liver Function Tests In Congestive Heart Failure

• Today, it is possible for the clinician to employ more tests in the evaluation of disease than ever before. However, as the author points out, the interpretation of these tests must be correlated with the clinical and physical findings.

CHARLES B. MOORE, M. D.†
New Orleans

IN 1942, speaking before a meeting of the American Medical Association, Chavez [1] said:

"One of the organs that suffers most in heart failure is undoubtedly the liver. Its enlargement is the general rule in right congestive heart failure. . . . But if it is easy to appreciate the anatomic alterations — enlargement, tenderness, hardness and the like—the functional attack often passes unnoticed or at least is clinically underestimated. It is only in the advanced stages when subicterus, or rarely icterus, appears or when digestive disturbances become important that the physician directs his attention toward the liver and admits the existence of hepatic insufficiency. Nevertheless, at much earlier stages of congestion laboratory procedures already show the functional attack of the gland."

In the ensuing years, much progress has been made in the laboratory evaluation of abnormal hepatic function. Currently available procedures permit accurate appraisal of the many facets of hepatic function. Application of some of these to determine hepatic function in patients with congestive heart failure has confirmed the myriad abnormalities present in this condition.

Some of the more useful laboratory examinations were employed in a series of patients with congestive heart failure in an effort to determine which tests are the most helpful in clinical practice and to document further the functional alterations that result when hepatic congestion with or without reduced hepatic blood flow is imposed upon a normal liver.

Material

This study includes 60 consecutive patients with congestive heart failure seen by me at Ochsner Foundation Hospital from August 1958 to January 1960. Routinely, a complete history was taken and complete physical examination was done. An attempt was made to exclude patients with a history of hepatic disease. The severity of the congestive heart failure was determined clinically. Routine laboratory procedures included electrocardiography, roentgenography of the chest, complete blood count, urinalysis, fasting blood sugar, blood urea nitrogen determination, fecal examination and serologic test for syphilis. In addition, the following liver function tests were performed initially, and in most instances, were repeated after therapy: bromsulphalein, serum bilirubin, total protein and albumin globulin ratio, serum glutamic oxalacetic transaminase (SGOT), serum glutamic pyruvic transaminase (SGPT), alkaline phosphatase, and cephalin flocculation. Twenty-four patients also had thymol turbidity tests, 18 zinc sulfate tests, and 12 serum electrophoretic patterns.

The patients were classified into four groups according to the severity of the congestive heart failure as judged clinically. Group 1 included 8 patients in whom the diagnosis of congestive heart failure was confirmed retrospectively after the therapeutic response was noted. Group II included 22 patients with definite fluid

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* Presented at the Eightieth Annual Meeting of the Louisiana State Medical Society, May 1-3, 1960, in Baton Rouge.

† From the Section on Cardiology, Ochsner Clinic, New Orleans.

retention, ankle edema, a slightly enlarged liver and only minimal limitation of activity. Group III included 21 patients with extensive fluid retention, definite limitation of activity and a large liver. Group IV included 9 patients with ascites and hydrothorax in addition to all the criteria of Group III. Patients with isolated left ventricular failure were excluded from this study. The methods used for the liver function tests and the normal values for these tests in our laboratory are shown in Table 1.

Results

Part. 1. Results of the tests will be discussed in relation to the frequency with which they were abnormal. Bar graphs were used to plot the distribution of the values within each of the four separate clinical categories for the procedures that seemed to bear some correlation with the clinical evaluation. These include serum glutamic pyruvic and glutamic oxalacetic transaminase, bromsulphalein, bilirubin, and alkaline phosphatase.

The serum glutamic pyruvic transaminase test is a measurement of the activity of the enzyme in its simultaneous conversion of alanine to pyruvic acid and alphaketoglutaric acid to glutamate. This enzyme is present chiefly in hepatic cells, and the test was introduced to help differentiate rises in glutamic oxalacetic transaminase due to hepatic disease from those due to other conditions. Of the 60 patients, 91.8 per cent had SGPT levels above the normal level before therapy. A definite relationship between the results and clinical appraisal of severity can be seen in Figure 1. In addition, a definite relationship between the mortality rate and SGPT levels was evidenced by the fact that all 6 patients who died

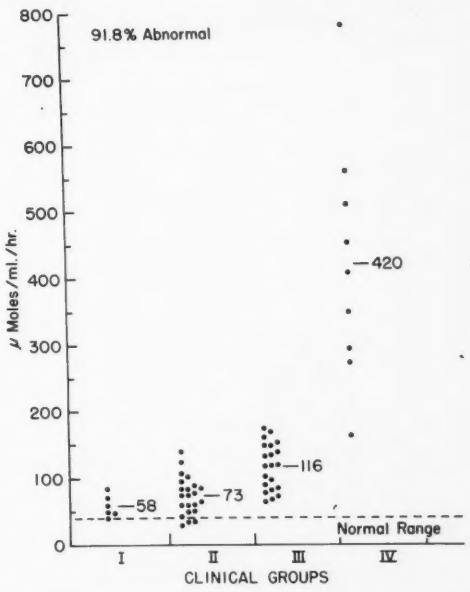

Figure 1.—Serum glutamic pyruvic transaminase levels in four groups of patients with congestive heart failure.

TABLE 1
NORMAL VALUES FOR METHOD OF LIVER FUNCTION TESTS USED

Liver Function Test	Normal Values
Bromsulphalein (2)	<6% retention/45 min.
Total protein (3)	6.0-8.0 Gm./100 ml.
Albumin	3.6-5.4 Gm./100 ml.
Globulin	1.5-3.4 Gm./100 ml.
Bilirubin (4)	<1 mg./100 ml.
SGOT (5)	<118 micromoles/100 ml./hr.
SGPT (5)	<40 micromoles/100 ml./hr.
Alkaline phosphatase (6)	<4 Bodansky units
Cephalin flocculation (7)	2 plus or less/48 hr.
Thymol turbidity (8)	<6 Maclagan Units
Zinc sulphate (9)	<10.5 units
Serum electrophoresis (10)	Albumin 44-60%
	Alpha 1 Globulin 3-6%
	Alpha 2 Globulin 8-16%
	Beta Globulin 10-17%
	Gamma Globulin 9-27%

had levels of SGPT more than four times normal.

Serum glutamic oxalacetic transaminase, an enzyme normally more active in the serum than SGPT, is also more widely distributed. It is involved in the simultaneous conversion of aspartic acid to oxalacetic acid and alphaketoglutaric acid to glutamate. As can be seen in Figure 2,

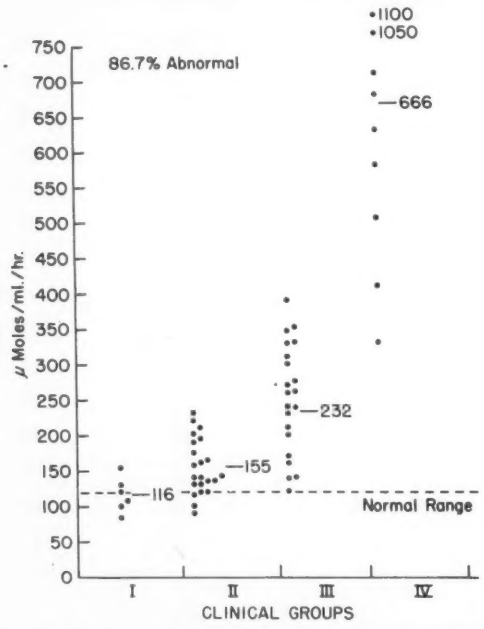

Figure 2.—Serum glutamic oxalacetic transaminase levels in four groups of patients with congestive heart failure.

the levels were above normal in 86.7 per cent of the cases and again good correlation was present between the degree of abnormality and clinical evaluation of severity of the disease. This test also seems to be a fairly sensitive prognostic guide, as levels more than four times the normal were often associated with fatalities.

The *bromsulphalein* test is a measure of the excretory function of the liver in the presence of normal hepatic blood flow. This latter condition is not always present in congestive heart failure and elevated bromsulphalein retention probably represents both decreased hepatic blood flow and altered parenchymal function. The bromsulphalein values were abnormal in 86.7 per cent of the cases and closely paralleled the abnormalities of the SGOT and SGPT, as well as the clinical appraisal of the severity of the process (Fig. 3). In addition, the bromsulpha-

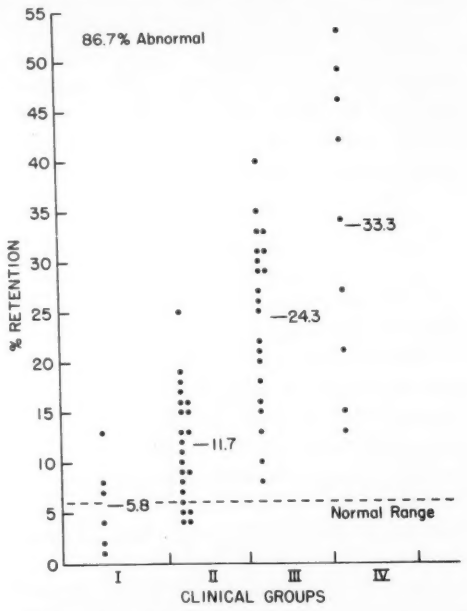

Figure 3.—Bromsulphalein retention in four groups of patients with congestive heart failure.

lein test seemed to be the best guide to prognosis, since all patients with bromsulphalein retention of more than 34 per cent died.

Bilirubin. The levels for total bilirubin are shown in Figure 4; again, the relationship between these and clinical appraisal is obvious. No pronounced elevations will be noted, however, and only about 20 per cent of the patients had clinically detectable jaundice, that is, a level of more than 2.5 mg./100 ml.

Alkaline Phosphatase. In Figure 5 it can be seen that although fair correlation exists between the height of the alkaline phosphatase and the severity of the disease, there are frequent normal values in the more severely ill patients. Only 40 per cent of the patients had abnormal values.

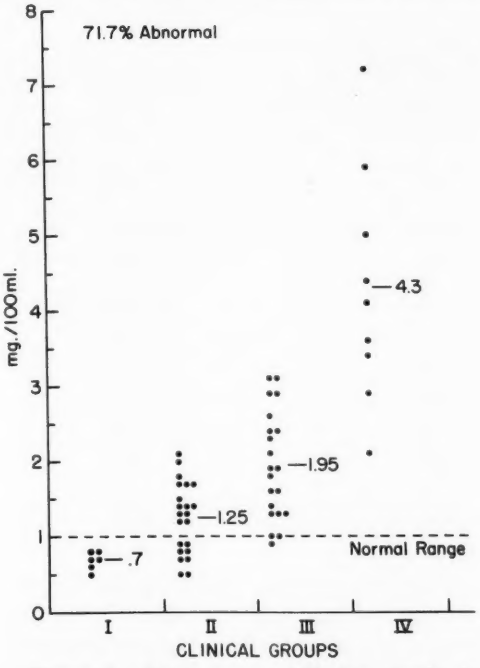

Figure 4.—Total serum bilirubin levels in four groups of patients with congestive heart failure.

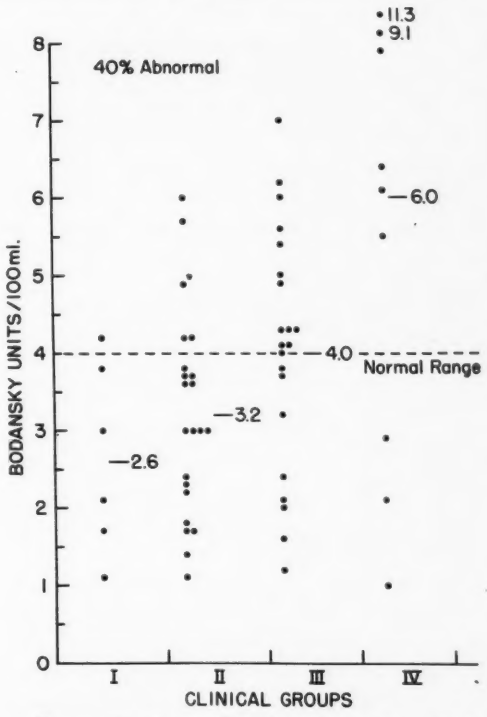

Figure 5.—Serum alkaline phosphatase levels in four groups of patients with congestive heart failure.

Total Protein and Albumin-Globulin. Although the values tended to be slightly lower than normal for the serum albumin fraction and slightly higher than normal for the globulin fraction, no predictable change was detected and, as standardly performed, this determination seems to be of no aid in clarifying the problem of congestive heart failure.

Flocculation Tests. Three tests, the cephalin-cholesterol, zinc sulfate, and thymol turbidity were performed. There was no relationship between the values of any of these tests and the clinical severity of the disease. Moreover, normal values were frequently encountered in critically ill patients. Sixteen per cent of the patients had abnormal cephalin flocculation values, 21 per cent thymol turbidity and 12 per cent zinc sulfate values.

Serum Protein Electrophoresis. As noted for the chemical determination of protein fractions, there was a slight tendency for the serum albumin levels to be lower than normal and the globulin fraction to be slightly elevated. This was not statistically significant by either method.

Part 2. Because these changes were thought to be due to congestive heart failure alone, it was believed that determinations should be obtained after therapy of the congestive heart failure in the patients in whom results were abnormal. The results of these studies for the five tests which showed a significant correlation with the clinical state are presented in Table 2. As can be seen, the values fell toward normal in every instance, although in the more severely ill patients, lesser degrees of abnormalities persisted after control of the congestive heart failure. This is considered to be presumptive evidence of cardiac cirrhosis in these patients.

Discussion

The large number of separate functions performed by the liver is well known. "Batteries" of liver function tests have

TABLE 2
ABNORMAL RESULTS OF FIVE LIVER FUNCTION TESTS BEFORE AND AFTER TREATMENT OF CONGESTIVE HEART FAILURE

		Clinical Groups							
		I		II		III		IV	
		B	A	B	A	B	A	B	A
Glutamic pyruvic transaminase	Ave.	58	37	73	29	116	31	420	84
	Range	40-84	19-44	28-140	21-42	64-174	18-54	162-780	40-94
Glutamic oxalacetic transaminase	Ave.	116	97	155	96	232	112	666	164
	Range	84-154	78-112	90-231	90-116	120-390	84-130	330-1100	98-222
Bromsulphalein	Ave.	5.8	3.1	11.7	2.9	24.3	3.5	33.3	8.2
	Range	1-13	1-6	4-25	1-5	8-40	2-8	13-53	4-16
Bilirubin	Ave.	0.7	0.7	1.25	0.7	1.95	0.94	4.3	1.3
	Range	.5-.8	.5-.8	.5-2.1	.5-.9	.9-3.1	.6-1.1	2.1-7.2	1.1-1.6
Alkaline phosphatase	Ave.	2.6	2.5	3.2	3.0	4.0	3.3	6.0	3.9
	Range	1.1-4.2	1.1-3.9	1.1-6.0	1.0-3.8	1.2-7.0	1.0-4.1	1.0-11.3	1.0-5.4

B = Before treatment
A = After treatment

been devised to measure these various parameters. The different types of tests may be divided into those related to: disturbance of albumin and globulin synthesis, specific protein synthesis, disturbed lipid metabolism, disturbed carbohydrate metabolism, enzyme alterations, excretory function, and biliary obstruction.[11] The detected abnormalities presented here fall chiefly into the realm of altered enzyme control, altered excretory function and abnormalities related to biliary obstruction.

The pathologic alterations in the liver after long-standing passive congestion are well known. The alterations of hepatic function associated with passive congestion are less well known but have been documented.[1, 12-19] Table 3 contains some of the results of others who studied this problem, as well as the abnormalities detected in the present study. The slight variations in the percentage of abnormalities noted is probably related to differences in the selection of patients. All authors except one [15] agree that the bromsulphalein is the most sensitive test of hepatic dysfunction in congestive heart failure.

The addition of the SGOT and SGPT tests to the physician's "battery" makes available two more sensitive tests of liver function. Although these tests suffer somewhat from lack of specificity, in the clinical setting of edema and congestion, it is helpful to know the height and duration of elevation of these two enzymes in confirming the presence of hepatic congestion. They tend to become abnormal before overt clinical evidence of heart failure is present.

The large number of abnormalities demonstrated to be present at some stage in congestive heart failure can be seen in Table 3 and points to the great alterations in cellular physiology present in this condition. If we turn from a simple measurement of the abnormalities to an attempt at understanding the pathophysiology involved, many problems and contradictions become immediately apparent. Although it is generally agreed that the bromsulphalein test is a good measure of altered function in passive congestion, the mechanism of this elevation is not known. It has been attributed to cellular hypoxia secondary to decreased hepatic blood flow by some [20] and to a combination of cellular hypoxia and hemorrhage from distended sinusoids by others.[12] Recently, however, in admittedly an artificial system, Brauer and associates [21] showed that bromsulphalein clearance by hepatic parenchyma is minimally affected by passive

TABLE 3
PERCENTAGE OF ABNORMALITY OF LIVER FUNCTION TESTS IN CONGESTIVE HEART FAILURE BY VARIOUS INVESTIGATORS

	Sherlock [12]	Felder [13]	Chavez [1]	Evans [14]	Wahl [15]	Moore
Glutamic Pyruvic Transaminase	—	—	—	—	—	91.8
Glutamic Oxalacetic Transaminase	—	—	—	—	—	86.7
Bromsulphalein	?	85	100	96.1	48	86.7
Bilirubin	68	52	85	26.4	41	71.7
Alkaline Phosphatase	10	46	—	—	—	40
Urobilinogen	92	—	75	—	—	—
Total Protein	—	29	—	—	80	31
Albumin	28	—	—	63	—	31
Globulin	42	18	—	23	—	28
Prothrombin Time	—	—	—	—	16	—
Takata-ARA	—	—	63.3	—	—	—
Thymol Turbidity	—	31	—	36.5	10	21
Cephalin Flocculation	—	22	—	27.2	57	16
Zinc Sulfate Turbidity	—	—	—	—	—	12

congestion if the effect of blood flow is eliminated. He concluded from his studies that distention of the tissues and consequent strain upon its structural elements, and the interposition of a fluid barrier between oxygen-carrying erythrocytes and oxygen-consuming cells in certain key regions are the two chief effects of passive congestion. The difference between the laboratory and clinical observations is probably attributable to the fact that hepatic blood flow is not maintained at a normal rate in patients with congestive heart failure.[22]

The problem regarding transaminase is also confusing. Initial thought was that the transaminases were excreted into the bile, since bile was shown to have a high content of these enzymes.[23] However, recently, this was questioned by Linde,[24] who was unable to confirm the high levels in bile. Certainly, disproportion exists between production and excretion in such conditions as acute myocardial infarction and acute infectious hepatitis. However, in the conditions characterized by lower and chronically elevated values for the enzymes, the exact cause for the elevation is not apparent. Chronic, low grade elevation of the SGOT has been reported in obstructive jaundice [25] and it may be that the mechanism of elevation of these enzymes in congestion is similar to that in obstruction of the biliary tree. These abnormalities are considered under the discussion of the rise in bilirubin. The possibility also exists that the liver actively secretes these enzymes into the blood stream as a response to chronic low grade damage both in obstruction of the biliary tract and in chronic passive congestion. This would be in line with a similar mechanism postulated to explain the rise in alkaline phosphatase in certain diseases of the liver.

In studying the cause of the elevation of bilirubin, Kugel and Lichtman,[26] in 1933, concluded that the factors of primary importance were: (1) duration and type of congestive heart failure and (2) lo-

cal factors favoring formation and absorption of bilirubin (infarction, hemolysis and infection). Sherlock [12] concluded that there are at least three separate mechanisms for the rise in serum bilirubin in congestive heart failure. One was attributed directly to inability of the parenchymal cells to excrete the bile pigment. The second relates to obstructive jaundice secondary to pressure on the outside by distended veins and by inspissated bile thrombi from within. The evidence of actual obstruction of the biliary tree is poor, however, and this mechanism probably plays only a small part in the production of jaundice. The third mechanism involves excessive production of pigment secondary to infarction—usually in the lungs—and the inability of the already damaged liver to excrete these pigments. This latter factor of impaired hepatic function is obviously as important as the excess production, since introduction of excess loads of pigment alone does not result in jaundice.[27] In a study of the problem of hyperbilirubinemia in congestive failure, Schalm and Hoogenboom [28] found that as the congestive heart failure subsided, if the bilirubin remained elevated, permanent hepatic damage was usually present.

Careful scrutiny of the abnormalities noted in this study will reveal that the changes in liver function tests in congestive heart failure are identical to those seen in cirrhosis, regardless of the etiology. There are no pathognomic changes in liver function tests which will make a diagnosis of congestive heart failure. However, the importance of these recorded abnormalities lies not so much in the clinical diagnosis of congestive heart failure, although on occasions they may be the initial clue to the problem, but in the knowledge that severe derangements in hepatic function may occur as a consequence of congestive heart failure alone. Therefore, before any exhaustive study of a patient is undertaken because of the finding of abnormal liver function, some thought should be given to congestive heart failure as a cause of this abnormality. The manifestations of congestive heart failure on liver function are so protean that congestive hepatomegaly must be considered routinely in patients with abnormalities of hepatic clearance or excretion of substances.

Summary

Liver function tests were performed on 60 consecutive patients with various degrees of congestive heart failure. The degree of severity of the process was assayed clinically.

In 5 of the tests (SGPT, SGOT, bromsulphalein, alkaline phosphatase, and bilirubin) there was a relationship between the severity of the heart failure and the degree of abnormality. The most striking correlation occurred between the severity and the SGPT, SGOT and bromsulphalein. In addition, the bromsulphalein test seemed to be an excellent guide to prognosis in that all patients with bromsulphalein levels greater than 34 per cent died. The SGOT and SGPT appear to become abnormal early in the course of hepatic congestion.

Results of the flocculation tests, which depend upon various alterations of the serum proteins, and the measurement of serum proteins themselves, showed poor correlation to the clinical appraisal of the severity of the disease and provided little help in arriving at a diagnosis of congestive heart failure. The abnormalities listed are identical to those seen in cirrhosis.

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Discussion

Dr. George M. Anderson (Lake Charles): I want to thank Dr. Moore for bringing to our attention the alterations and interpretations of liver function tests occurring with congestive heart failure.

Elevations in transaminase determinations occur not only in acute myocardial infarction but also in cirrhosis, viral hepatitis and very early congestive heart failure.

Serum transaminase determinations are most useful in the study of patients with acute chest pain, particularly those whose electrocardiograms indicate old myocardial damage. Elevated transaminase determinations in these cases may be due to early heart failure or cirrhosis and not to actual myocardial infarction.

Transaminase determinations obtained in patients who experience tachycardias of over twelve hours may be elevated due to heart failure and liver anoxia which may not be detected by physical examination.

As always laboratory determinations are important in the study of patients but must be correlated with the history and physical examination to give them the proper interpretation.

Toxemic Diseases and Their Treatment

W. R. Sevier, M.D., Jonesboro, Tenn.

"If I am correct in the views expressed touching the practicability of disinfecting the blood, it will readily occur to the intelligent reader that, in the properly regulated use of the muriated tincture of iron, with or without a super-addition of hydrochloric acid as may be found best, will be found a plan of protection from both cholera and yellow fever far more efficient and reliable than that afforded by quarantine and one, too, which will not in any measure disturb the peace of society nor the interests of commerce. I beg that I may not be esteemed sanguine, without reason, when I express a confident hope that this fact will be established."

New Orleans M. & S. J. 7:849 (March) 1880.

Hypersensitivity to Marsh Elder: Difficulties Encountered in Patch Testing

• The necessity for testing with materials that the patient is in contact with, when testkits prove unavailing, is borne out by the report of this case

OLLIE WILLIAMS, M. D.
RICHARD SPEAIRS, Ph.D.
H. WHITNEY BOGGS, M. D.
Shreveport

ALLERGIC eczematous contact dermatitis is the most common skin condition seen by the practicing physician. The most practical and valuable test procedure used in the diagnostic approach to this problem is the patch test, and frequently we can rely on materials that the patient handles either at work or at home, or which the individual is in contact with in the environment, such as herbaceous trees. When it is necessary to resort to standard antigens prepared by commercial laboratories, we must be sure that contactants of our region are included. When considering various "weeds" and plants, of which there can be numerous subspecies of each genera, failure to include all of the known offenders in a regional area can be misleading to the investigator. We have an interesting case which is enlightening in this respect.

Case Presentation

A 37 year old W.M. oil field worker was first seen by us in April, 1958, with history of recurring generalized dermatitis and hay fever of fifteen years' duration, there being an increase in severity of symptoms for the past three years. He had been treated by a number of physicians over the years, treatment consisting of steroids, ACTH, antihistamines, sedatives, tranquilizers and various types of topical treatment. The patient noted that the dermatitis responded minimally to therapy on occasions and seemed to improve about January or February of each year, only to flare up during late spring or early summer.

Physical examination revealed a generalized weeping eczematoid dermatitis, most severe on the dorsum of the hands and forearms, V-area of the chest and face. Allergic contact dermatitis was suspected, but complete testing with scratch and patch tests to the known plants, broadleaf weeds, grasses, trees, as well as foods and materials that he handled at work, were negative. After repeatedly questioning the patient about possible contactants, he mentioned a "weed" that seemed to make the hay fever worse. Patient was patch tested to a small amount of this weed and within six hours the material had to be removed due to the terrible itching. Examination the following day revealed a 4-plus bullous reaction, classical of the positive patch test reaction. (Figure 1).

This particular weed was identified as Iva microcephala Nutt., one of 15 known species of marsh elder. Since the allergy testkit contained "Marsh Elder", and was prepared by a private concern, we reasoned that this patient apparently was sensitive only to this particular species of Marsh Elder, which was not present in the antigen provided. Testing with "Marsh Elder" antigen prepared by Graham laboratories of Dallas, Texas, produced a reaction identical to that obtained with the weed itself, thus the reaction was quite specific for this species of marsh elder, and no cross antigenicity between the antigen produced by the private concern and that produced by the plant itself (and which was present in Graham's testkit) was noted.

Botanical Aspects

The plant in question was identified as *Iva microcephala Nutt.*, according to Small.[2] It is a member of the tribe Heliantheae of the family Compositae. Related common genera include *Xanthium* (Cocklebur), *Ambrosia* (ragweed), *Rudbeckia* (Black-eyed Susan), *Cosmos* and others. Gleason [1] notes that there are perhaps 15 species of *Iva* native to North and South America. Eight species and one variety are recorded in the literature

* Presented at the Seventy-ninth Annual Meeting of the Louisiana State Medical Society, in New Orleans, May 6, 1959.

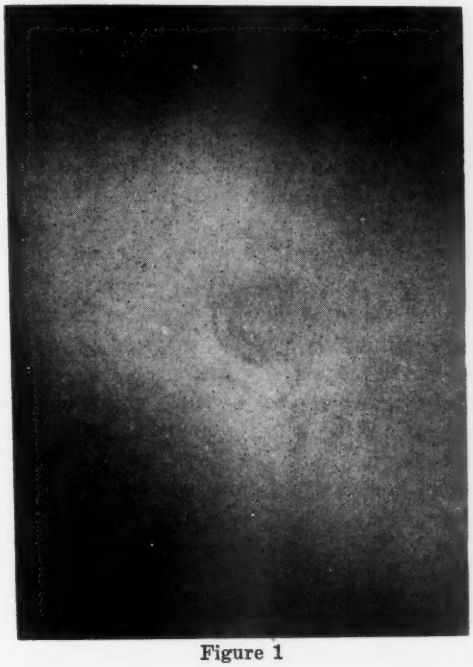

Figure 1

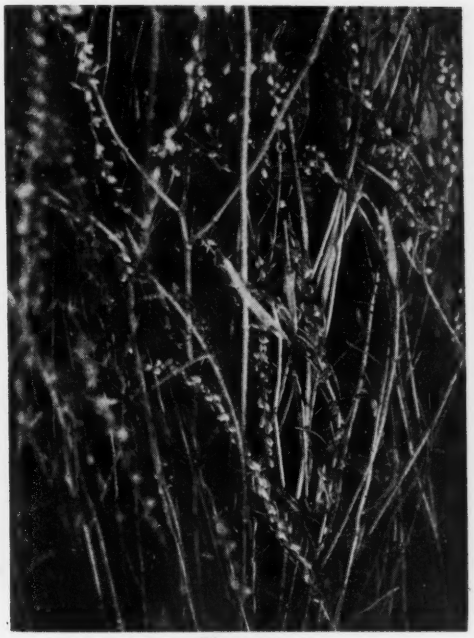

Figure 2

of the flora for the area east of the Rocky Mountains. Seven of these species have been reported in the south and southeastern states. Three species, *I. augustifolia, I. asperfolia* and *I. microcephala* have been reported only from areas adjacent to the Gulf from Pensacola, Florida, westward to Texas, extending about 400 miles inland. These plants are found in dry pinelands and waste places and bloom from summer on to the first killing frost, with flowering occurring until the winter kill of the plant.

Description of the plant is as follows:

Iva microcephala Nutt. Annual glabrous or nearly so, slight. Stems erect, 3-9 dm. tall, much branched above, the branches slender, erect or ascending; leaves often alternate; blades narrowly linear, 2-5 cm. long, acute, entire, or slightly toothed: heads numerous, sessile or nearly so: blades narrowly linear to linear filiform, surpassing the heads; involucres 3-6 flowered, campanulate, 2 mm. high; bracts oblong to cuneate, obtuse to retuse at the apex; fructiferous flowers 3; corolla nearly 2 mm. long; achenes about 1 mm. long.

Discussion

There are numerous patients seen by dermatologists and allergists whose history and physical findings suggest allergic contact dermatitis, yet innumerable testing procedures fail to réveal an etiological agent. As in our patient, testing with materials that the individual is in contact with can prove rewarding. Contact dermatitis of the hands is a frequent cause of trouble with housewives, and persistent testing to the numerous materials used in the home can often reveal unsuspected allergies. Actually the type and number of contactants are legion, and what treatment is more specific than simple avoidance of contact to which an individual may be hypersensitive. Invariably a long standing contact dermatitis will complicate with secondary neurodermatitis, as did our patient, but this should not misguide the diagnostic approach to the problem. Lymphomas frequently produce findings identical in appearance to contact dermatitis, as do rarer conditions that we see, such as polymorphic light eruption. If suspicious of an allergic etiology every means available

should be exhausted before ruling out this possibility.

Testkit material is generally identified by common names. This practice is satisfactory for a number of the plants in which there is no duplication of the use of the name for other species in the same genus or even other genera; however, in this case three species of *Iva* and one of *Baccharis* have the term "Marsh Elder" incorporated in the common name as noted below:[5]

Iva fructescens var. *oraris* Bartlett
Common Marsh-elder or High-water Shrub

Iva ciliata Wild
Rough Marsh-elder or Sumpweed

Iva xanthifolia Nutt.
Marsh-elder or False ragweed

Baccharis halimifolia L.
Marsh-elder or Groundselbush

The other species of *Iva* have not been designated by a common name, but would likely have the name "Marsh Elder" included in their common nomenclature should a common name be ascribed to them.

Summary

A patient with long standing chronic generalized dermatitis was found to have an allergic contact dermatitis due to a species of Marsh Elder common only to the Gulf Coast area; he had been followed for twelve years with a diagnosis of neurodermatitis.

The correct diagnosis was established on the basis of positive patch test to the weed itself, having been missed when the patient was tested to an allergy testing kit provided by a private concern. Specific antigenicity of this regional plant is established due to the fact that the individual failed to react to the "Common Marsh Elder" antigen supplied in a standard testkit.

Patient has been started on a desensitization program, and with avoidance of this weed should eventually be relieved of his problem.

Conclusions

When evaluating patients with possible allergic syndromes, every means should be exhausted to establish what offending antigen is causative, and if standard testkits are unrevealing, patch tests to materials that an individual handles at work or at home, or comes in contact with in the environment, should be carried out.

Also, companies preparing testkits should keep in mind the fact that there are numerous species of various types of herbaceous trees, grasses, and pollens, these being species specific or subspecies specific in their antigenicity; yet no cross antigenicity may be associated with the more common antigens used in their testkits.

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Discussion

Dr. Phillip R. Loria (New Orleans): I think Dr. Williams is to be congratulated for his extensive botanical research as regards this case. It was with a great deal of foresight that he disregarded previous patch test results with the idea of trying the local antigen. He is to be commended for this basic and all-important approach to a patient with an allergy. The fact that he used the local antigen may well be a tremendous boon to a patient with an eruption of fifteen years' duration.

Those patients with a generalized skin eruption or one predisposed to the typical atopic areas have proven to be very difficult as regards management. It is extremely difficult at times to wait for the condition to subside sufficiently in order to do patch tests. Under such circumstances perhaps one is justified in doing the patch test anyway as the condition can usually be brought under control by using corticosteroids if it should flare.

We are all familiar with the concept of "broadening of the base" in allergy. While the allergen discussed in this case may be a secondary allergic factor, yet it is a most tangible bit of evidence on which specific therapy may be designated. It may be that the future will reveal other factors as well.

An interesting facet that may be more thoroughly investigated would be the results obtained with this patient as regards the passive transfer test and precipitin test as discussed by Cohen in his recent article in the A.M.A. Arch. of Dermat., (March) 1959, in which he discussed two patients with seasonal ragweed dermatitis and in whom he showed these various factors to be in existence.

There Is Danger in a Kiss

Very many of the diseases to which we poor mortals are liable can be prevented, provided proper efforts are put forth to meet that most desirable end.

This truth no one will gainsay, still, the subject has not yet attracted the attention its importance demands, and it appears now to be the especial duty and province of those of our profession who live in this day of preventive medicine to erect finger boards along the highways of life, which shall point out clearly and plainly the known causes of disease. * * *

There is oftentimes danger in a kiss, notwithstanding Lord Byron, that prince of poets, in the days gone by, expressed the wish

"That womankind had but one rosy mouth,
To kiss them all at once from North to South."

Ah! it was a bad wish even for so bad a man, and so faithless a lover as he, yet it does seem that he was not peculiar in this respect, since in this glorious age of enlightened progress, such sickly sentimentality is no less popular, and has no fewer votaries than in the days of old, because kissing, **kissing**, KISSING is still the order of the day.

The ladies kiss each other upon every offered opportunity, every flimsy pretext; the poor little children, and even the babies are made to do likewise in compliance with the requirements of genteel society, and the men too, would do the absurd thing at every meeting were it not for the lamentable truth that they are obdurate and have not yet been educated up to the sound, civilized and philanthropic principle of "dog eat dog."

Payne, R. L.: Quoted in New Orleans M. & S. J. 7:714 (January) 1880.

Primary Carcinoma of the Liver Associated With Laennec's Cirrhosis A Case Report

• Primary carcinoma of the liver is relatively rare in the Untied States, and in approximately two-thirds of the cases reported cirrhosis is present.

ROBERT KAPSINOW, M.D.
Lafayette

PRIMARY carcinoma of the liver continues to be a challenging disease because it is comparatively rare in this country. It presents major diagnostic, as well as therapeutic problems, since few cancers have a poorer prognosis once the disease is recognized. Virchow is credited with the dictum that such organs which are the frequent sites of metastases, are rarely the sites of primary neoplasm. This is particularly true of the liver, for while metastatic malignancy is frequent, primary carcinoma is rare indeed. Moreover, primary carcinoma is also unique because of its geographical and racial distribution. All evidence suggests that its incidence is highest in countries inhabited by the yellow and dark-skinned races [8] and is lowest in the United States and Western Europe. Even in the U. S., the incidence in the American Negro is 0.44 per cent, while in the general population it is 0.26 per cent.

Wilson [5] reports that only 20 cases of primary carcinoma of the liver were found in 35,995 admissions in ten years. Sanford [6] quotes Gustafson, who found 62 cases of primary carcinoma of the liver occurring in Bellevue Hospital in the performance of 24,400 necropsies. This is an incidence of 0.25 per cent. In these cases cirrhosis was present in 64.1 per cent of the liver cell variety and in 33.3 per cent of the cholangioma group. Schupach and Chappell [7] observed 14 cases of primary liver carcinoma in 797 consecutive necropsies at the Kennedy Veterans' Hospital since 1946. This incidence of 1.76 per cent is in striking contrast to the 0.26 per cent found for Americans generally. Only in the Asiatics and Africans is the incidence so high. The incidence of primary liver cracinoma varies somewhat percentagewise in the different reports which were studied. However, the general impression obtained was that carcinoma as a primary lesion of the liver is relatively rare, especially when the types are considered.

Cirrhosis is both a precursor and a consequence of primary liver carcinoma. The exact relation, however, is not known. In a survey of the literature, it is estimated that in approximately two-thirds of the reported cases of primary liver carcinoma, an associated cirrhosis is present, which is of the Laennec type. It has been postulated that the rapid regeneration and repair that occur in cirrhotic livers may lead to carcinomatous change. Galluzi et al.[1] found that 10 of 16 patients with liver carcinoma had Laennec's cirrhosis. Macdonald [2] stated that in 72 cases clinically reviewed, the following types of cirrhosis were found: 21 fatty nutritional cirrhosis, 20 healed acute yellow atrophy, 6 hematochromatosis, 4 undetermined type cirrhosis, 4 biliary cirrhosis, and 17 with no underlying cirrhosis. The significance of the association of cirrhosis with primary liver carcinoma lies in the increasing incidence of both viral and serum hepatitis, which may at a later date become converted into cirrhosis. Bloch and Chazan [3] suggest three theories as follows: that cirrhosis precedes and influences the development of carcinoma; that it is secondary to the neoplasm; that cirrhosis

and malignancy of the liver have the same provocative factors.

In children, there are too few examples in the liver of the combined lesions to permit analysis. Of 52 per cent of reported primary liver carcinoma in children under the age of two, cirrhosis was found in only two children.

In a survey of 18 cases of Lemmer,[4] cirrhosis of the liver was found in 55.5 per cent. Bloch and Chazan state that cirrhosis of the liver is present in 87 per cent of adults with primary carcinoma of the liver. Although in their survey of 90 collected cases in children from the European and American literature, only 2 patients were found to have cirrhosis. Macdonald found that in a series of 108 tumors, 82 or 76.9 per cent were associated with cirrhosis.

Pathology

Primary liver carcinoma is usually found as one of three types. Grossly by appearance they are classified as (1) massive, (2) nodular and (3) diffuse infiltrating.

1. In the massive type, one finds a single, large, irregular tumor mass involving one lobe, usually the right. There may be other smaller satellite nodules, but the lesion is limited to the one lobe.

2. The nodular type is characterized by multiple tumor masses varying in size and consistency.

3. The diffuse type is also frequently called the infiltrating, or carcinomatous cirrhosis. Grossly the liver is extremely scarred by cirrhotic bands enmeshing many tiny nodules. This is so much like the appearance of Laennec's cirrhosis, that unless a liver biopsy is taken, the diagnosis will be missed.

Microscopically, primary carcinoma of the liver may be divided into three major histologic classes: (1) hepato-cellular or malignant hepatoma of the liver cell type, (2) the bile duct cell type or malignant cholangioma, and (3) the cholangio-hepatoma, or mixed type.

1. The hepatomatous type[8, 9] is the commonest form of liver cancer. It arises from the parenchymatous liver cells and consists of polygonal or polyhedral shaped cells. This form is frequently associated with cirrhosis either as multiple nodules of varying sizes and shapes, or as a massive growth involving a large portion of the lobe. Except for a satellite dispersal around the individual large tumor mass, the rest of the liver is normal. The nuclei show much variation in size, shape and staining characteristics. These cells are capable of secreting bile, but whether it is chemically normal, has not yet been determined because of the difficulty of collecting it for analysis. A cirrhotic reaction is common. This type of liver cell carcinoma differs from the bile duct or cholangiomatous type by virtue of the septa of capillary stroma.

2. The cholangiomatous or bile duct carcinoma arises from the epithelium of the intrahepatic bile ducts. These cells are cuboid or cylindric, with small hyperchromic nuclei. The cell morphology is more constant. The tumor cells tend to form glands and ducts. The massive solitary form of tumor is not seen in this type. Here the growth is scattered throughout the liver.

3. The mixed or atypical group consists of cholangio-hepatomas, which is a combination of neoplastic proliferation of bile duct cells and liver parenchymal cells. Sections of this type show a greater preponderance of the bile duct cell type due to its more rapid growth propensity. In some series studied, this mixed group is considered the most common variety.

Hepatic Cirrhosis and Liver Cancer

Most investigators regard the frequent coincidence of cirrhosis with primary liver carcinoma as an important intermediate stage in the carcinogenic process. In Africa and Asia it is unusual not to find carcinoma without cirrhosis. Both Berman[10] and Macdonald[2] found a greater incidence of cirrhosis in the hepatocellular cancer. Ewing is quoted as reporting 85 per cent of liver cell cancer as against 50 per cent in bile duct cell cancer, with cirrhosis. Where hepatic cirrhosis is infrequent, there also primary liver cancer

is uncommon. Counseller and McIndoe [8] are quoted as stating that the authenticity of a diagnosis of primary carcinoma of the liver is questionable in the absence of cirrhosis.

The reparative processes which usually follow liver damage tend to overgrowth and actual hyperplasia. It has been theorized that these isolated nodules of hyperplasia may eventually undergo malignant change. Why some of these nodules remain benign and others malignant, is as yet unknown. The possibility of a derangement in the cellular enzymatic metabolism which affects cell division, due to hyperactive oxidative changes, seems very intriguing to contemplate.

Numerous factors are credited with causing cirrhosis that possess carcinogenic or co-carcinogenic capabilities. These are as follows: (1) intestinal parasites, (2) liver fluke, (3) schistosomiasis, (4) hydatid cyst, (5) syphilitic hepatitis, (6) infectious hepatitis, (7) hemochromatosis and siderosis, (8) alcohol, (9) spiced foods, (10) keloid diathesis especially in the Negroid races, and lastly (11) possible viral hepatitis.

Clinical Features

The clinical picture of primary carcinoma of the liver is variable.[15] The symptoms are more usually those of a rapidly deteriorating cirrhosis associated with cachexia, weakness, and weight loss. The amount of ascites present depends upon the rapidity of the malignant growth, i.e., the more rapid the neoplastic growth, the less ascites, because the life expectation is shorter. In the presence of cancer, there may be more pain discomfort than with cirrhosis alone.[11] Usually it is more a picture of gall bladder disease. The pain is in the right upper quadrant. It is dull, aching and constant and may or may not be associated with the ingestion of certain foods.

Weakness, weight loss, fatigue with varying degrees of icterus are present. Cachexia is rapid. Laboratory findings are of no help at all, other than directing the attention of the observer to a derangement in liver physiology.

Carcinoma of the liver may occur at any age.[3] It is most infrequent in childhood and most often between the fifth and seventh decades. Males are most affected, although Boyce and McFetridge [12] reported primary carcinoma in two Negresses in a New Orleans Charity Hospital survey.

Diagnosis

Diagnosis must be made positively by liver biopsy at celiotomy. This author is opposed to needle biopsy of the liver for diagnosis, not only because of the chance of missing the lesion, or from possible hemorrhage, but because a more accurate appraisal of the situation can be made by direct inspection.

Treatment and Prognosis

No matter how much the various reported series may differ as to symptoms and signs of the disease, all are agreed upon one point, namely, the rapidity with which they are fatally terminated once the diagnosis is made.

So far as treatment is concerned, when the primary liver carcinoma is associated with cirrhosis, surgery is futile. Resection of a lobe or part of a lobe for the solitary adenomatous lesion has been done by Pack and others. This is the only type that offers any hope for survival. Wilson [13] noted that the first successful resection of a portion of the liver, done by an American, was Keen in 1897. This he did by exteriorizing the tumor of the liver and with hat pins and elastic bands, caused it to slough out. Pack has been most successful in his results, by lobar hepatectomy, but these were on the isolated pseudo-encapsulated types of massive tumor.

The pathologic features of primary carcinoma of the liver render surgical treatment nearly futile. Hepatic replacement by tumor with physiologic insufficiency renders the majority of these patients poor surgical risks. Metastatic lesions are present in over one-half of the cases at post mortem and gross venous invasion in at least one-sixth of the patients.

Case Report

F.O.'F., white male, age 72, was seen on October 28, 1959, because of pains in the right upper quadrant which had become constant, but were worse on deep breathing. The pains were sharp and knife-like especially if he moved or coughed. The onset was dated as one week prior. His appetite, which had always been good, had begun to fail. There was no nausea or vomiting. The bowel movements were regular but he had never noted the color of the stools. The pain did not seem to be related to his food. He had no fever, although he stated that he thought he had fever. Neither he nor his wife had noted any change in the color of his skin or eyes.

There had never been any previous history of a similar attack of pain, nor did he give a history of jaundice. He had been a rather moderate drinker over the years.

Upon examination, the patient was found to have lost a little weight. His temperature, pulse, and respirations were normal but it was noted that breathing was painful and he kept his right hand over the gall bladder region as if to splint it. His weight was 178½ and his B. P. 160/80. He complained of severe pain in the right upper quadrant when he coughed or took a deep breath or even to move about. His face was plethoric with a yellowish tinge and a circumoral pallor. Heart sounds were normal and regular. Lungs were free of pathology. The abdomen was not distended, nor were there any enlarged veins present. The upper abdomen was held rigidly and muscle spasm was obvious in the right upper quadrant. The abdomen was tympanitic. The liver and gall bladder were not palpable. There were no enlarged lymph nodes in the neck, axillae, or groin. The spleen was not palpable.

The laboratory findings were as follows:

Urine—Dark yellow, acid, 1008, negative for sugar and albumen, bile 4+, urobilin 4+, occasional pus cell on microscope.

Blood—B.U.N. 9.6 mgm %. Fasting blood sugar 134 mgm %. WBC 17,000; P-56; L29; M14; E1. Negative for malaria. Hbg. 15.75 gm or 101%. Hct. 51%. Sedimentation rate 13 mm/1 Hr. Serum was heavily bile tinged. Negative Wasserman and VDRL.

Prothrombin time: 14 sec., 100% of normal. Clotting time 5¼ min.

Bilirubin: Direct 1.88 mgm%; total 4.30 mgm%.

Stool, negative for bile.

Liver function tests: Thymol 2.3 units. Alkaline phosphatase, 4.56 units. Transaminase SGO-T 50 units per ml. SEP-T 48 units per ml.

X-rays: Gall bladder: Attempted gall bladder visualization failed to show a gall bladder shadow. No stones were identified.

Short G. I. Series: No evidence of any ulcer or other pathology of the esophagus, stomach or duodenal cap with the exception of hyperplastic rugae in the pyloric antrum and the suggestion of some prolapse of the gastric mucosa into the duodenal cap. The duodenal loop was somewhat rounder and the upper part of the second portion of the duodenum did not fill completely. The findings were not sufficient to consider a tumor of the head or the pancreas.

Chest—E.P.A. of the chest shows the lungs to be clear. Cardiac, aortic, and hilar shadows are within normal limtis of size. Slight calcification of the wall of the aortic knob is apparent.

Electrocardiogram—Normal.

Preoperative diagnosis — Acute exacerbation of chronic cholecystitis with common duct stone, or possible carcinoma of the head of the pancreas.

The abdomen was opened through a right upper rectus incision. The liver was enlarged, hard, and highly lobulated in both lobes. The gall bladder was distended. After aspiration, no stones were found. The common duct was slightly distended. No stones were palpated. The stomach and duodenum were normal. The stomach was elevated and the lesser omental space opened and the pancreas explored. The pancreas was generally enlarged. The head felt larger and harder than normal. No areas of necrosis were found. No enlarged lymph nodes were seen or palpated. Because of the jaundice and the positive findings of obstruction, and the suggestive evidence of pancreatic carcinoma, a cholecystojejunostomy was performed. A large wedge-shaped section of the liver was then taken for biopsy.

Pathologic Report: Hepatic sections showed distortion of the lobular architecture with irregular bands of lymphocytic infiltrated fibrous tissue extending throughout. There were many vacuolated hepatic cells, and the nuclei showed regenerative changes. There were multicentric foci of anaplastic tumor cells with deeply basophilic cytoplasm. The nuclei varied markedly in size and contained prominent nucleoli. There were bizarre multipolar mitosis.

Diagnosis—Liver cell carcinoma, multicentric. Lobular cirrhosis, Laennec.

The postoperative course was rapidly down hill. Pain persisted. Jaudice became more marked. Anorexia, vomiting and weakness increased. The patient expired five weeks after his first examination.

Postmortem — The findings in the abdomen were essentially the same as at surgery. No obstruction was found in the common duct to account for the positive laboratory tests indicating extrinsic hepatic obstruction. No carcinoma was found in the pancreas. The entire liver

was invaded by the diffuse anaplastic growth. No metastases were found elsewhere.

Summary and Conclusion

A case of primary diffuse carcinoma of the liver associated with Laennec's cirrhosis has been reported. Primary carcinoma of the liver is rare in the U.S. There are three types found: massive, nodular, or diffuse. These are again classified histologically as liver cells or hepatic, bile duct cell or cholangiomatous, and the atypical or mixed cell type. The high incidence of association with cirrhosis may be more than coincidence. Derangement in the enzymatic metabolism provoked by the cirrhosis during the regeneration of the hepatic tissue, is an interesting speculation. The increasing frequency of cirrhosis following both serum and viral hepatitis, may result in a greater incidence of primary carcinoma of the liver. Diagnosis is usually difficult and seldom made antemortem. Only in the solitary unilobular lesion, is surgical intervention possible. Life expectancy is otherwise usually very short.

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Sea-Weed As An "ANTI-FAT"

The use of the variety of sea-weed botanically known as **Fucus vesiculosus** for reducing obesity has obtained recognition in professional circles abroad. Dr. Fairbanks writes to the **British Medical Journal** as follows: "More than fifteen years ago, I gave some of the extract in pill (four grains, three times a day) to a very corpulent lady, who in three months lost three stones in weight without any change of diet. Since then I have frequently given it for reducing weight depending on the accumulation of adipose tissue, and have never found it to fail. The solid extract can be easily made into four grain pills, which must, however, be kept in a stoppered bottle as they readily absorb moisture from the air. I may say that a patient who has been lately taking it as an anti-fat and who has always suffered very much from rheumatic pains about the body, has been entirely free from such trouble while she has been taking the extract, a fact which she quite independently noted.—Boston Journal of Chemistry, October.

New Orleans M. & S. J. 7:708 (January) 1880.

Popular Misconceptions Concerning Nasal Function*

• Postnasal drip and nasal congestion are the two chief complaints magnified by some patients into an importance out of proportion to any existing pathology.

R. S. HENDRICK, M.D.
Shreveport

OFTEN one of the most baffling and trying problems with which a physician can be faced is that of the patient coming to the office with a complaint of nasal obstruction, excessive nasal secretions, headache which occurs in the morning, postnasal drip, or frequent colds and the like. In the group of patients under discussion today, the most dilligent examination discloses no evidence of nasal deformity or of suppurative disease. The fact that there is an important subjective element involved in most of these complaints adds greatly to the difficulty in diagnosis and treatment.[1]

Various authorities have stated that probably 75 per cent of all nasal complaints coming to a doctor's attention are functional rather than organic in nature.[2] In the treatment of these patients a brief consideration of the physiology of the nose and the probable factors producing alteration in it would make the cause of the symptoms and the treatment of these symptoms obvious.

Many of these unfortunate individuals have been subjected to destructive nasal and pharyngeal surgery which has only added new symptoms to the old, leaving them in such a state that it is impossible to afford them relief.

Before we go further let's take a brief look at the internal anatomy and physiology of the nose.

Anatomy

The septum separates the nose into two nasal chambers and forms the medial wall of each. The skeletal portion of the septum is composed of the quadrilateral cartilage anteriorly, the perpendicular plate of the ethmoid above, the vomer and the rostrum of the sphenoid posteriorly, and a ridge below made up of the crest of the maxillae and the crest of the palatines. On the lateral wall there are two large turbinates (the middle and inferior turbinates) and usually one and sometimes two rudimentary ones above (the superior and supreme turbinates). The middle, superior, and supreme turbinates are part of the ethmoid labyrinth. The inferior turbinate is a separate bone and is attached to the ethmoid and the maxilla. The middle and inferior turbinates are long fleshy bodies hanging downward from the lateral wall and extending horizonally almost the full length of the wall. They are supplied with swell bodies or cavernous venous spaces which serve to adjust their size. The entire mucous membrane of the nose and sinuses is a ciliated pseudo-stratified columnar epithelium.

Physiology

The principal function of the nose, other than olfaction, is to act as an air conditioner.[1] The inspired air during the brief passage through the internal nose is cleaned, moistened, and adjusted as to temperature. The journey of four inches from the nares to the choanae takes not over one-fourth of a second yet the relative humidity when it reaches the pharynx is 75 per cent or more and the temperature is about 97 degrees no matter what the temperature was a quarter of a second previously just off the tip of the nose. All dust, bacteria, and particulate matter

*Presented at the Seventy-ninth Annual Meeting of the Louisiana State Medical Society, in New Orleans, May 5, 1959.

have been removed and the air is ready to be received into the lungs.[3]

The turbinates and their integument are the principal structures involved in this process and we may state that nasal physiology depends upon the integrity of the turbinates. The anterior end of the inferior turbinate directs the inspired air upward principally past the middle meatus where the air is split into thin sheets and then passes backward into the pharynx.

The glands of the nasal mucosa form a continuous mucus blanket over the surface of the functioning part of the nasal epithelium. This blanket supplies moisture to the inspired air and engulfs foreign particles in its tenacious substance. Both serous and mucus cells are present in the glands and the relative amount of water in the secretion and its viscosity are determined by the relative amount of water and mucus produced by these cells. It follows that there is a delicately adjusted secretory control which responds to the demands of the environment. The amount of mucus produced during a twenty-four hour period varies from person to person but it averages between one and a half and two quarts. The nasal mucus membranes are most active at puberty and after the late twenties their activity diminishes and they gradually atrophy.

The pH of the mucus blanket is about 7, or in other words, neutral. This is important because if the pH varies much the cilia do not function well. Neither does lysozyme, an antiseptic enzyme which not only kills bacteria but causes them to dissolve.

The cilia are continuous over the surface of the functioning portion of the nasal mucous membrane. There are 25 to 30 cilia on each cell.[3] The cilia stroke at between 200 and 250 cycles per minute.[1] The strokes of the individual cilia are not just a waving back and forth. Each stroke has a powerful rapid phase in the direction of flow. This is followed by a slower movement of recovery in which the cilium bends. The waves of ciliary activity are directed posteriorly in the nose and in the sinuses the direction of flow is circular toward the ostia.

The two nasal chambers alternate in their activity, one side becoming engorged and blocking the passage of air, while the other side is secreting, opening, and allowing the passage of air. This alternate opening and closing varies from person to person, the alternation varying between half an hour and two hours.[4]

According to variations in the temperature and relative humidity, the cavernous tissue on the medial surfaces of the turbinates becomes more or less congested in order to vary the cubic capacity of the nasal chambers and by controlling the volume of inspired air to prepare the chambers for environmental changes. Variations in temperature have a more marked effect on the cavernous tissue of the turbinates. Variations in humidity have a more marked effect on the serous and mucus cells of the glands. Extremely dry air places a greater demand upon the serous cells while a humid climate places the greater burden upon the mucus producing cells. The content of mucin in the blanket remains close to 3 per cent. If it becomes more dilute or concentrated, the blanket will have too much or too little viscosity to be handled by the cilia of the underlying mucous membrane.

Physiologic Complaints

The most common complaints offered by patients concerning the nose are based on either misinterpreting normal physiologic action as disease or misinterpreting the effects of senile changes as disease.

Many patients complain of the alternating obstruction produced by the normally functioning nasal chambers. In the past removal of the turbinates for this complaint has led to much real secondary atrophic changes in the nasopharynx, oropharynx, and larynx. The passage of time will usually overcorrect a hyperactive nasal mucosa so usually an explanation of the physiology will relieve the patient's apprehension.

Another complaint is the closing of the dependent side of the nose during sleep.

This is caused by the action of gravity on the tissue fluids in producing a congestion of the mucosa of this side of the nose. These complaints can be accentuated if a septal deflection tends to occlude the side which would normally be open. Usually in these cases an extra pillow under the head plus an explanation of the physiology involved will relieve their anxiety.

Probably the commonest complaint is postnasal drip. It has been passed down from generation to generation that there should be absolutely no drainage from the nose into the back of the throat. Prior to the turn of the century such drainage was termed "catarrh." At the present time the terms "postnasal drip" or "sinus trouble" cover such drainage quite adequately. At any rate, if such drainage is present it is thought to be pathologic and to swallow it would "poison the system."

To certain hypersensitive individuals their postnasal drip is an extremely serious symptom. They seem to have their inward eye constantly focused on their nose and throat. They are convinced that they suffer from a debilitating and as yet incurable disease. Their morning ritual of clearing, harking, and spitting is deadly serious. They will often state that despite all their efforts they always swallow some of the secretions. This nauseates them and they vomit. Many of these people actually end up vomiting every morning. During the day they continue periodically clearing the nasopharynx and say that the mucus is so thick that it won't come down. Examination of the nasopharynx reveals no trace of excess secretions. Here nature plays a mean trick on them. The more they clear the more it feels as if it needs to be cleared. These tense individuals often have globus hystericus; thus they also complain of thick mucus low in the throat which they can't clear up or swallow down.

These are the ones with whom we frequently have to spend the most time. If we are hasty and explain away their symptoms as "due to nerves" and give them another bottle of nosedrops to add to their already bulging medicine cabinet we have done them a serious injustice. We must try patiently to explain normal nasal function to them. Emphasize that the feelings are quite real, not imagined, and that the clearing habits and associated anxiety magnify them. A few are almost beyond contact with reality and they leave your office convinced that you were just trying to explain away your inability to find the "real trouble." Though many seem skeptical at first, it is gratifying to see the large number who do accept the explanation of their symptoms, break the clearing habits, and are completely relieved. These are numbered among your most grateful patients.

Many persons mention their postnasal drip only in a review of systems and in a casual manner with a certain element of pride; pride in the fact that they are able to lead normal lives with the same symptoms that others find almost incapacitating. This tends to make one feel that he is made of sterner stuff. Often they actually enjoy their clearing, harking, and spitting ritual. It is part of the routine of getting down to the office. To deprive such people of this pleasure might be cruel. Injured pride heals slowly if ever.

A large number of persons are true nasal neurotics.[5] The patient presenting this syndrome insists that he has nasal obstruction despite all objective evidence that the nasal passages are normal and adequate. He will sniff with great force and insist that the resulting noise is due to obstruction. He doesn't realize that the forceful inspiration acts reflexly to close the nostrils and make the inspiration audible. With each successive forceful sniff, the blockage which was originally not present, develops and increases. The membranes react as though they must warm, moisten, and filter this more rapidly moving air. He now demands more airway and often undergoes destructive surgery or begins to depend on nosedrops. His standard of normalcy quickly changes. He accepts the cool feeling of the constricted membranes as normal. The original benzedrine inhaler helped develop an entire generation of nasal neurotics many of whom were phy-

sicians given free samples. The open nose and the mild euphoria were irresistible. Here again the treatment lies in re-educating the patient. The anti-histamines are of benefit plus the use of progressively milder and milder constrictors until they can eventually be discontinued.

In addition, there are milder manifestations of emotional effects upon the nose. For instance, we are all familiar with the nasal obstruction and watery discharge associated with crying. In a number of patients their nasal symptoms vary directly with their marital ups and downs. Another example is the so called "diplomatic cold" which appears when necessary to its owner and vanishes just as readily when it is no longer needed. The pitcher of water is at the speaker's table not because he is thirsty but because he is dry both in the mouth and nose. All too frequently little anxieties, many of which are almost unrecognized, express themselves as a dryness of the mouth and nose.[2]

Many nasal complaints are referable to age. I mentioned earlier the marked increase in the cavernous tissue of the turbinates at puberty. Therefore, between the ages of about fourteen and thirty many persons complain of stuffy nose and alternating obstruction. In former years such persons underwent turbinectomy which produced temporary relief at the expense of creating lifelong pharyngeal irritation and a crusty nose. After the age of twenty-five to thirty the nasal mucus membranes and particularly the turbinates begin to atrophy. As a result the nose becomes less and less efficient as an air conditioner. The inspired air rushes through the enlarged nasal chambers without being sufficiently cleansed or humidified and on striking the posterior pharyngeal wall sets up a region of inflammation by breaking the mucus blanket. This explains the frequent hacking cough of elderly individuals. Dryness of the mucosa produces a subjective sensation of nasal obstruction. Stimulation of the secretory powers of the nasal mucosa will provide a certain measure of relief. The expectorants are of some value but the iodides seem to be of the greatest value. A properly used oil spray may produce a coating of oil over the surfaces to replace the deficient or absent mucus blanket. Oil has insufficient viscosity to be moved by ciliary action so it may afford protection for a considerable time. The oil spray must not be inhaled because of the possibility of lipoid pneumonia.

Occupations which produce constant irritation of the nasal mucosa or occupations which by rapid alterations of the environment demand rapid functional changes in the nasal mucosa are likely to result in hyperactivity of the nasal mucosa. Thus persons who work around irritating fumes or others whose work exposes them to sudden marked changes of temperature may complain of stuffy, runny nose and postnasal drip. The treatment is either to change the occupation or else endure the nasal symptoms.

Other symptoms which I will mention only in passing are the marked nasal congestion just before and during menstruation, and the nasal congestion of pregnancy. The increased activity of the nasal mucosa during sexual excitement is marked and is sometimes called "honeymoon coryza." Myxedema and hypothyroidism without myxedema produce nasal congestion.

Disorders of the autonomic nervous system also influence nasal function. Vasomotor rhinitis or the physical allergies cover too broad a field to be discussed at this time but I will mention that the nasal congestion, sneezing, and watery discharge are brought about by the action of some physical agent upon the skin such as a sudden change in temperature of the skin or the effect of sunlight on the skin. The anti-histamines are of help here but of equal importance is explaining the condition to the patient.

Lastly, I will mention the alteration in nasal function caused by the misuse of drugs. The standard irritant used by our forebears was a strong salt solution snuffed through the nose, often mixed with bicarbonate of soda because of its ability to "dissolve mucus." In recent years this pernicious solution has lost favor to

the better advertised and even more irritating new products but certain of our senior citizens still swear by it. It is very hard to watch your favorite "Western" these days on television without being deluged by the advertising of various nasal sprays and nosedrops. They brag about their antibiotic properties, about their substances which dissolve mucus, and about their substances which relieve sinus congestion. Each product vies with the others in proclaiming the "number of ways" in which their product relieves symptoms. The number of ways increases each week and is beginning to sound like the national debt. The patients whom we have been talking about are sitting ducks for such advertising.

Sympathomimetic drugs such as epinepherine, ephederine, benzedrine, and the others, because of their frequency of use, are responsible for most of the nasal congestion due to the misuse of drugs. The primary action of constriction is followed by a refractory secondary relaxation. As a result, a condition is produced in which more and more of the drug has less and less effect, while the congestion of the nasal mucosa is more marked and ensues more and more rapidly. Chronic congestion of the mucosa is thus produced and it is particularly marked in individuals who have been addicted to the use of these substances for a number of months. Here again, the treatment lies in re-educating the patient plus the use of progressively milder constrictors until they can eventually be discontinued.

Summary

It has been estimated that probably 75 per cent of all nasal complaints coming to a doctor's attention are functional rather than organic in nature. Most of these complaints are based on either misinterpreting normal physiologic action as disease, or misinterpreting the effects of senile changes as disease. In the treatment of these patients a brief consideration of the physiology of the nose and the probable factors producing alteration in it would make the cause of the symptoms and the treatment of these symptoms obvious.

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Discussion

Dr. Jack R. Anderson (New Orleans): Dr. Hendrick's paper contains an uncommon amount of common sense about nasal complaints. It should be read and its contents noted and applied by all who treat such cases. A few of the points Dr. Hendrick makes are worthy of emphasis and elaboration.

When a patient complains that his nose is blocked, it should not be invariably assumed that edema of the intranasal tissues is the cause. In many instances, the word "stuffy" would more accurately describe the condition. Apparently, to experience a sense of normal breathing, (1) a certain amount of negative pressure must be developed on inspiration, and, (2) a definite degree of moistening of the inspired air must occur. Extremes at either end of the scale result in a sensation of "stuffiness" which patients loosely describe as "blockage". Examples of this are common clinically; thus, patients with markedly deviated nasal septa will often complain of blockage on the side which is most patent, and those with early (and advanced, too) atrophic rhinitis without crusting will report that they suffer with nasal blockage even though there is actually an increase in the volume of the nasal passages. It is important to make this clinical distinction for prescribing the usual vasoconstrictor medications for such patients is definitely contraindicated.

Aside from bacterial allergy and exposure to low humidity, the most common causes of nasal stuffiness, in my experience, have been reactions to fear and anxiety, excessive smoking, excessive coffee drinking, and endocrine hypofunction due to advancing years. Fear and anxiety cause sympathetic stimulation. Tobacco smoke, in addition to being a local irritant, acts systemically and also produces vasoconstriction. Coffee, as a result of its caffeine content, also causes vasconstriction, and, because it is a potent diuretic, also causes dehydration and thickening of the nasal mucus. Anything that causes prolonged vasoconstriction in the nasal mucous membrane will cause a decrease in the amount and an increase in the viscosity of the mucus produced. Thus, the nasal passages will be open

widely, and yet the patient will say it is blocked. Usually, these patients will complain of a seeming paradox; they report a great deal of dryness of the nose and throat and yet complain bitterly of the thickness of the mucus and the difficulty they experience in trying to rid themselves of it.

Something should be said about postnasal discharge for so many people think it is an indication of something which they vaguely describe as "sinus." One type of postnasal discharge is normal—we all have mucus, produced in the nose, which passes down the lateral walls of the nasopharynx to the hypopharynx to be swallowed. The postnasal discharge resulting from purulent sinusitis is usually foul-smelling, has a sweetish-sickening taste, and proves irritating to the pharyngeal tissues and so causes pain. Individuals complain of nonpurulent postnasal discharge either (1) when the amount of mucus is profuse, e.g., as in allergic rhinitis, or (2) when the mucus is thick and does not move normally across the membranes, but, rather, rolls over in masses. In the latter instance, the patient becomes conscious of the thickened mucus and begins to make strenuous efforts to remove it. Sometimes, as Dr. Hendrick mentioned, an actual fixation develops and efforts to obtain relief become persistent, and often violent, and actually lead to nausea and vomiting.

A more rational approach to the treatment of nasal complaints would be obtained if physicians would heed Dr. Hendrick's admonitions and would, in addition, make wider use of the microscopic study of nasal secretions.

I have enjoyed Dr. Hendrick's presentation and wish to thank and congratulate him for bringing these practical facts to our attention.

Dr. E. W. Raggio (Lake Charles): I would like to congratulate Dr. Hendricks on his excellent presentation and Dr. Anderson on the excellent discussion. These gentlemen leave me without very much to add.

However, I would like to place additional emphasis on the point that "postnasal drip" is a very common complaint and can be quite troublesome to doctor and patient alike.

I find it more difficult to make a diagnosis of a functional or psychosomatic condition than one having an organic or infectious basis and for that reason I would like to point out two things that the patient might have, but could be labeled psychosomatic unless we have them in mind.

As we all know the nasal membranes are related to general bodily functions and are therefore affected by such conditions as hormonal imbalance and allergic states.

Allergy, especially the perennial nasal allergy, may cause the complaint of stuffy nose and postnasal drip. In diagnosing this condition a family history of allergy is helpful and finding preponderance of eosinophiles in the nasal secretion with the microscope and stained smear will clinch the diagnosis of allergic rhinitis.

The treatment for this is, of course, based on skin testing and food testing to find the offending allergen, which is in most cases house dust and molds. Treatment with the specific allergen will give excellent relief.

Hypometabolism is also responsible in a few instances. This can be diagnosed with basal metabolism, protein bound iodine and blood cholesterol tests. Better results are obtained when the B.M.R. is done under sedation i.e., Seconal gr. 3 the night before and Seconal gr. 1½ one hour before the test. If the sedated B.M.R. is minus 15 or the P.B.I. is low or both and the blood cholestrol normal or high, treatment with tyroid extract or Cytomel is indicated and generally relieves the nasal symptoms.

Proceedings of the Attakapas Medical Association
Second Meeting, New Iberia, Nov. 27, 1879

"Resolved that the second article of the Constitution be read. Motion adopted.

"The article was read as follows:

"The objects of this association shall be the pursuit and cultivation of the practice of medicine, and the sciences on which the same is based, together with the defence of rights and elevation of the dignity of the medical profession; also the protection of the professional interests of its members, and the cultivation of harmony and fraternal feeling among the members of the profession within its boundaries.

"On motion of Dr. M. W. Richardson, duly made and seconded, it was

"Resolved that a committee be appointed whose duty it shall be to examine the statutes of the State, and if found necessary, to draw up a petition to the Legislature, at its next meeting, requesting that a law be passed for the protection of the qualified and regular practice of medicine, against quackery, and the unqualified practice of medicine, midwifery and surgery within the State."

New Orleans M. & S. J. 7:740 (January) 1880.

Organized Medicine and the Crisis in Community Health Programs*

• The author believes that the medical profession is losing its position of leadership in community life and presents reasons for the changing position of organized medicine.

BEN FREEDMAN, M.D.
New Orleans

Unity of Medicine and Public Health

PUBLIC health and medicine have grown and developed from the same roots. Their subject is human beings in social settings. Their aims are to prevent and control the occurrence of disease and disability, to ameliorate the sufferings of the sick and prevent such conditions from shortening life, to rehabilitate the disabled as much as possible to social usefulness and self-reliance, and to promote conditions for optimum physical and mental health for individuals and communities. This wisdom of health has evolved through the centuries by a process of selective incorporation of the knowledge of nature and society into a humanitarian framework of application. Public health and medicine, therefore, are rooted in the natural sciences, nourished in the social sciences, and nurtured in a philosophy of ethics, steeped in a creed of humanism.

This statement is neither new nor radical. It has been professed over and over again in various ways by medical and public health societies since their inceptions, and by the individual leaders in medicine and public health at various times through the current of medical and public health history. The medical profession, therefore, has played a leading role of responsibility in initiating and stimulating the growth and development of community health programs from the beginning.

Before the onset of specialization, medicine and public health were an ideological unity. The dedicated physician was a community leader—the central figure and confidant around whom the people rallied in times of stress, and upon whom they depended for individual and community guidance and succor. Nothing could have been more natural than such a relationship between the physician and his people.

Some physicians today still play an inspiring role in community health affairs, but the profession's relationship to the people has suffered significantly. No longer does this relationship carry with it the sparkle and reverence of the past, nor the strength, nor the vigor, nor the vibrancy. A new leadership has insinuated itself into the realm where the physician once prevailed, and it is challenging his position. This leadership has arisen from various non-medical fields and from the ranks. It is stepping into the vanguard in community life where physicians have lost their vigilance and have failed to express their sympathy to the health needs of the community and to keep abreast in the struggle to help the community solve its health problems. This does not mean that the traditional free-giving of services by physicians has diminished. Not at all. Physicians are still the most generous givers of services to the needy. It is in the field of comprehensive planning to solve community health problems that the organized medical body has failed.

Let us trace the course of these developments. Before the period of mass production and public education, when commerce and urbanization were in the earlier stages of growth and development, the destructive communicable diseases were the greatest problem of communities and phy-

* Presented at the Eightieth Annual Meeting of the Louisiana State Medical Society, in Baton Rouge, May 4, 1960.

sicians. The care of the individual was a perplexing problem, indeed. Due to the undeveloped state of medical knowledge, the results of the physicians' ministrations were mediocre to say the least. Death rates were high. Infants had a problematic chance of survival. The average length of life from infancy for the common man was scarcely more than a score of years. The opportunities for surviving were matters of medical responsibility. The leaders in medicine pondered, philosophized, discussed, argued, fought, and wrote on these problems. They found quicker solutions in empirical preventive techniques than in therapeutics, and acted rapidly in applying these to their communities. Nevertheless, their theories, hypotheses, and speculations set the stage for modern science, and created the instruments of community health practices which are the basis of modern public health organization and administration. In fact, the essentials of good public health practices such as quarantine, isolation, vaccination, nutrition, excreta control, stream pollution, and housing began long before the science of bacteriology was founded.

The methods used by communities in controlling communicable diseases were simple techniques whose application generally required a minimum of disturbance of those social and cultured habits and interrelationship which might violate traditionally established sensibilities and evoke deep-seated, antagonistic, emotional eruptions from the community and medical profession. At this point, one may cite the example of small-pox vaccination, and the antagonisms which its application called forth when introduced to the western world. But even here, the acceptance of this simpler technique spread rather rapidly. During that period, the medical profession concerned itself not only with the individual problems of health but also with every aspect of public health that was recognized as a public matter.

A New Era — A New Problem

Now that the mortal epidemic diseases of yesteryear have been largely controlled or prevented, the main causes of death and disability are presenting a new spectrum. A few of the chronic communicable diseases such as tuberculosis, syphilis, and rheumatic fever still linger dangerously in our midst, although the main killers of our day are neither acute nor communicable in nature. In 1958, heart disease, cancer, vascular lesions, and accidents accounted for 71 per cent of all deaths in the United States. But why have such diseases as syphilis, tuberculosis and rheumatic fever not been more satisfactorily controlled, and why are the above mentioned noncommunicable conditions coming so strongly to the fore? The main reason is that the problems involved are socially more complicated. Such simple technical procedures as quarantine, isolation, immunization, and water or excreta control are no longer valid to cope with these problems. Control is bound up with measures of complex social involvement such as are associated with housing, nutrition, interpersonal and intergroup relations, medical care, and income. The complex social problems involved in controlling these three diseases are compounded several-fold in dealing with the prime killers and disablers of today, particularly the behavioral aberrations. The manipulation of these socio-cultural factors may, and do in many instances, give rise to a disturbance of social interrelations and cultural practices which usually are bound up with antagonistic emotional responses. For medical practitioners, the problem involved here relates mainly to disturbances of the traditional interrelations involved in giving medical care. *Organized medicine's reaction to solving this problem decidedly affected its leadership in community health programs and its relation to public health in general.*

The Nature of Change in Society and Medicine

Let us review how it came about that, under the impact of quickening social changes initiated by modern methods of mass production and the process of urbanization, the medical profession is losing

its position of leadership in community life. In scanning the history of the transitional period that led us into the present era, the reason for declining leadership of organized medicine becomes quite clear. Organized medicine has not changed the social outlook of its interrelations with society, even though society itself has changed profoundly and the medical profession has markedly changed the technological aspects of its practice. This needs to be understood thoroughly by the profession and therefore needs to be analyzed in some detail. In order to do this, I would like to posit three theses which appear to be inevitable in the process of modern social development:

1. Science will continue to give us an increasing flow of knowledge that will lend itself to mass application for control of disease and for promotion of better health.

2. Communities will increasingly seek to apply such knowledge to protect themselves against the ever-pervading fear of sickness, and to realize the age-old dream for universal good health.

3. The more that community health programs are put into operation, the more will people seek medical care from the medical practitioner, and the more stable will become the economic status of the profession as a whole.

A fourth thesis will be posited later which will clarify the position that organized medicine must take as a result of what is happening.

The above three theses have not been well understood by organized medicine or the profession in general. This is why a crisis in medical leadership has developed both in official public health and in other community health programs.

Fear and Its Consequences

Why has the medical profession not understood these basic theses? The only reasonable and historical answer is: because of *Fear*. This fear has manifested itself in three basic ways:

1. The physician fears a change in the *relations* between himself and the patient, between government and the medical profession, and between government and patient. He has a vivid picture of the descriptions he has read and heard of the happenings in Europe in the field of community health programs. He fears similar developments at home. He fears that the confidential and professionally intimate *relationship* between himself and his patient, which is so important in good medical care, will be destroyed. He also fears that community health programs have a tendency to attract government control and to stimulate government to organize more widely distributed community health programs. This, he fears, will engender control over him and interfere with his creative, experimental, and observational freedom, besides generating economic controls on income. He further fears that the government may exert an inordinate control over the patient which may upset the traditional patient-physician relationship.

2. The physician fears changes in the age-old *institution* of private practice of medicine — a heritage of practicing his profession in an atmosphere of almost complete freedom from social controls. He has reacted to such controls even when he himself deemed them necessary. For example, he rebelled against medical licensing boards, although he helped to create them. He rebelled against the reporting of births and deaths and certain diseases, although he laid the basis for these controls. He is now rebelling against almost any form of organizational change in the application of medical knowledge to community health which he fears may possibly bear the seeds of modifying his status as a private practitioner, although the knowledge which he has created is helping to facilitate the emergence of such changes.

3. The physician fears change or interference with the *customs* and *traditions* (the *mores*) of his profession such as remaining free from the responsibility of accounting to his peers or to the public for continuing his educational growth, or for the way he manages the diagnosis and treatment of his patients. He fears inter-

ference with his right to sell his service without social restriction and to freely donate his services for the welfare of the community as he sees fit.

Organized medicine's inability to deal rationally with the three theses which are inevitable in the process of modern social development has served as an incubator for breeding these fears. This set of circumstances has led to the crisis in medical leadership where community health programs are concerned, and particularly where these programs deal with medical care.

How has this crisis manifested itself?

1. Organized medicine has developed an almost obsessed suspicion of community organized health programs, particularly when administered by government. Because public health agencies are the traditional operators of community organized health programs, public health physicians, who are agents of the government, have received the brunt of the private practitioners suspicions and have been tolerated with reluctance in organized medicine's circles.

2. This tendency to isolate public health physicians (who certainly have also contributed to their own isolation) has to a large extent, sterilized their imagination, frozen their aggressive leadership, and separated them from joining their medical confreres in the struggle to find solutions to the perplexing socio-medical problems.

3. Like public health physicians, the salaried physicians in private and voluntary organizations have suffered similar discrimination because being salaried has given them the same status as public health physicians in the eyes of organized medicine.

4. Organized medical groups are very often found aligned against community health programs, without themselves offering suitable solutions for the health problems involved.

5. Despite the deterrent effect on the public health physician's creative ability in developing and operating community health programs due to his medical brethren's opposition, all types of community health programs have been emerging like mushrooms everywhere, including health insurance and medical care programs.

6. A great many community health programs and most of the medical care programs have been organized and are being administered by nonmedical agencies. These agencies make an ostentatious display of enlisting the advice of the medical profession and to hire physicians to do the medical work, but the pattern in planning and administering these programs is ultimately the reflection of the attitudes, ideas, and wishes of the nonmedical administrators, and these are too often in conflict with the requirements of good medical and public health care and with the sensibilities of the physicians.

Medical Leadership and the Fragmentation of Health Services

Thus, by default of the medical profession, community health programs are coming into existence and are being operated without medical leadership and in opposition to the values and ideals as well as the prejudices of private practitioners. Our quarrels, however, cannot be with these nonmedical agencies. They recognized certain health needs of the community, and met those needs in the way they thought best, while organized medicine neither admitted that it recognized the needs nor presented workable counterproposals to meet these needs. When the community becomes convinced that it has a health problem, and the medical profession refuses to take the lead in solving it, can we blame nonmedical agencies for coming to grips with the problem?

In the wake of organized medicine's surrender of leadership, a serious fragmentation of health programs has resulted. Preventive medical programs have become separated from therapeutic programs, the medical aspects have been separated from those of environmental hygiene, and the rehabilitation programs have been isolated and insulated in a serene sphere by themselves. Thus, a comprehensive approach to family health problems and to those of the individual

has become almost impossible by the fragmentation of health services.

Let us see how this fragmentation has manifested itself in Louisiana. With few exceptions such as institutional services, public health programs of a medical nature had traditionally been operated by the State Board of Health up to the end of World War II. Since then, important new programs have been established, many of which are being operated by agencies with nonmedical direction and nonmedical orientation. At present, the sight conservation program, the program for partially sighted pre-school children, the greatly expanded medical care program for the needy, and the day care nursery program are being operated by the Department of Public Welfare; the evaluation center program, the mental health program, the nursing home program, the dental trailer program, and the hospital and health center construction program are under the direction of the Department of Hospitals; the medical aspects of the vocational rehabilitation program and of the program for exceptional children are under the administration of the Department of Education. Few persons who know the details of the operation of our state health programs have failed to realize how the separation of the planning and management of these health programs have reduced their efficiency and effectiveness and have increased their administrative costs. For the medical profession, the control of medical programs by nonmedical direction has still another significance — the alienation of medical management from the physician. The legend of the physicians' ineptitude as administrators has been spread far and wide by nonmedical groups and has been one of their important rationalizations why physicians should not administer community health programs. Organized medicine's apparent indifference to the problem of who administers medical programs has gone a long way to support the legend of the physicians' ineptitude in these matters.

Fear and the Question of Validity

Let us examine to what extent the fears of organized medicine are valid. Certainly, we, as a profession, have shown little fear of the development of new medical knowledge during the last half century, nor fear of the technical changes in use of drugs and diagnostic methods. Thus, although we have shown no fear of change in medical knowledge and technology, our fears have, however, been directed toward social and cultural changes. Is it reasonable and is it normal to harbor such fears? Fear of social and cultural changes is normal for individuals and groups just as acceptability of such changes is normal. But a normal reaction is not necessarily a reasonable one. An impulsive reaction may be normal, but impulse does not spring from reason. To accept the development of knowledge and consequent changes in technology while at the same time impulsively fearing the social and cultural changes that must inevitably follow, indicates that our profession has been more successful in objectively reasoning about the virtues of knowledge and technology, but has not been so successful in its objectivity toward social and cultural changes. It is clear, therefore, that we have not been reasonable about social and cultural changes, and this is mainly due to our restricted understanding of the implications. Medical science and technology cannot be divorced from science and technology in general. Even the superficial observer of history is acquainted with the fact that our present stage of knowledge and technology could not have developed without the kaleidoscopic social and cultural changes which accompanied the industrial revolution and which have been taking place more and more rapidly ever since. Those who expect technological changes to take place without concommitant social changes are living in a dream world, and those who consider themselves reasonable and still oppose through fear the observable social changes in the modern world are basing their opposition and fears on a profound invalidity. There should be apprehension to the coming of

change, but the apprehension should be the stimulus to try to understand the forces involved in the process of change and to try to direct the change in the channels that will be best for the society.

If the apprehensions of organized medicine are directed toward such changes as may possibly prevent the practice of medicine in an atmosphere not conducive to creativeness, to freedom of developing one's potentialities and predilections, to social recognition of one's contributions to society, and to a livelihood commensurate with one's social position, then such apprehensions are justifiable, since all these undesirable conditions could possibly come into being. It would even be reasonable for these apprehensions to become downright fears if there were no logical approach to prevent their happening.

Logic, Knowledge, and History

Is there then, a logical solution to this problem? There is evidence to believe that there is, and that the history of mankind points to *objective knowledge* as the instrument with which to do this. Therefore, our first step is to alert our consciousness that reason colored with a minimum of emotional overtones must prevail over ideation laden with emotional agitation. Accepting this, reason will also accept the premise that change is part of the process of social development and therefore is inevitable, and that the more rapidly knowledge accumulates and technology develops, the more rapidly would we expect concommitant social changes to take place. Under these circumstances the medical profession must work out its strategy and direct its organized will, being conscious of the three theses posited earlier in this paper. However, there is yet a fourth thesis that must be added at this point, and this thesis is the mainspring from which the hope, the expectation, and the faith is born that a strategy reflecting the organized will of the medical profession can be successful. This thesis can be stated as follows: *Man can shape his own world*, if he uses the existing conditions in his society as the matrix to work with. To be successful, however, he must understand the dynamics of the existing social conditions. This knowledge will give him the instruments to shape the future by directing, as far as is possible, the forces at hand for the well-being of the individual and the society. Equipped in this manner, we, the medical fraternity, can help to make our own history.

The organized will of the medical profession, however, cannot successfully contend against the organized will of society. It can, however, help society to realize its hopes and desires by planning with it and directing its desires into channels capable of creating conditions best suited for the profession to give its best in maintaining the highest standard of medical practice.

Since community health programs tend eventually to find a harbor in the administration of government, the medical profession must seek to ally itself with government, and to express its leadership in government health administration. And since boards of health and health departments are the most universal of government agencies that are administrated by physicians, the logical ally of organized medicine in government is the public health physician.

Regaining Leadership

Medical leadership in community health programs, therefore, can be most aptly regained:

1. By the alliance of organized medicine with public health agencies. These are natural allies. Both are inspired by the same heritage and both are steeped in the same ethical philosophy. The health officer and private practitioner belong to the same fraternity; their work is complementary; their aims towards society are the same, although approached from different but converging paths.

2. By organized medicine and public health agencies jointly studying the community's health problems and needs, and becoming the pioneers in proposing and implementing community health pro-

grams. We must anticipate the community's changing health needs, and not wait to be prodded into action.

3. By insisting that community health programs conducted by government be planned, organized, and administered by medically directed agencies such as health departments in order that both the people's and physicians' interests be protected.

We, physicians, must join the inevitable march of events. Let us anticipate the people's needs, hopes, and desires. Let us be continually forging community health programs to meet the changing needs of the people. Only then will we, the whole medical fraternity, be able to influence the shape of events to come, and to preserve the essential elements of physician-patient-government relations, the institution of private practice, and the physician's freedom to pursue his professional aspirations in the best course of his tradition.

Transactions of the American Medical Association
Instituted 1847, Vol. XXX, 8 vo. pp. 1028, Philadelphia, 1879

The present, being one of the largest volumes issued by the Association, contains much matter of the highest interest and value, and indicates that its vitality is not entering on a decline with advancing age.

The address of the President, Dr. Theophilus Parvin, is upon **Teleology**, in which he takes the ground that the old doctrine of creative design in the universe is not superseded by the modern doctrine of evolution, but may be made to harmonize with it. Abundant quotations from philosophers and men of science are adduced to support his position, and his paper is interesting and valuable, though probably not convincing to pronounced evolutionists.

* * * *

The **Address in State Medicine and Hygiene** was made by Dr. John S. Billings, U. S. A. He strongly advocates the utility of the registration not only of deaths but of diseases, as furnishing a more accurate index of the state of the public health than simple mortuary statistics. In this he is undoubtedly right, but we fear that his scheme will never become practicable in our day.

A very instructive paper follows on **State Medicine and State Medical Societies**, by Dr. Stanford E. Chaille, of New Orleans.

Reviews and Book Notices: New Orleans M. & S. J. 7:836 (February) 1880.

The Journal of the Louisiana State Medical Society

Established 1844

Published by The Journal of the Louisiana State Medical Society, Inc. under the jurisdiction of the following named Journal Committee:

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1430 Tulane Avenue

Subscription Terms: $4.00 per year in advance, postage paid, for the United States; $5.00 per year for all foreign countries belonging to the Postal Union.

News material for publication should be received not later than the eighteenth of the month preceding publication. Orders for reprints must be sent in duplicate when returning galley proof.

Manuscripts should be addressed to the Editor, 1430 Tulane Ave., New Orleans, La.

The Journal does not hold itself responsible for statements made by any contributor.

Editorial

Officers of the Louisiana State Medical Society

The Louisiana State Medical Society in its recent Annual Meeting in Baton Rouge, from May 2, to May 4, elected officers for the coming year. The choices which have been made are a credit to the Society and an honor to the recipients.

The President is Dr. O. B. Owens of Alexandria, who is well known to all the physicians of the State, and who is a valiant worker in the cause of organized medicine. He brings to the office mature judgment, resulting from years of work for the good of the Society and the presidency is a most fitting tribute to him. We can confidently expect that he will guide the organization in these difficult times with professional skill and with effective leadership.

The President Elect is Dr. Cuthbert J. Brown of New Orleans, a surgeon well known locally and throughout the State. Dr. Brown has been active in the Orleans Parish Medical Society of which he is a Past President. He has been Chairman of the Committee on Congressional Affairs, and has served on many committees of the State Society. His stability, knowledge, and high regard for his fellow practitioners is respected by all. His friends and fellow physicians are happy that he has been so honored.

Dr. Arthur D. Long, of Baton Rouge, retires from the position of immediate Past President. He will continue to be active in our councils and to render his valuable assistance in the difficulties which face us. The Society is greatly indebted to him for his two years as President and Past President, and has great satisfaction in the fact that he is still available when needed.

The first Vice President is Dr. Frank Jones of Baton Rouge, to whom the membership is greatly indebted as the Chairman of Arrangements for the recent meeting. His efforts on behalf of the Society were most effective, and for this the membership is appreciative.

Dr. William C. Rivenbark of New Orleans, an outstanding pediatrician con-

tinues among the Vice Presidents to the pleasure of all. The Third Vice President is Dr. S. L. Gill of Shreveport who brings to the Executive Committee a broad experience in the Caddo Medical Society and gives promise of adding much to the stability in the counsels of the organization.

The membership of the Council shows only one change. Dr. J. E. Clayton of Norco was re-elected councillor for the Second District; Dr. C. E. Boyd of Shreveport for the Fourth; and Dr. Henson S. Coon of Monroe for the Fifth. Dr. Felix A. Planche, who has been long a Councillor for the First Congressional District, requested retirement and Dr. Spencer B. McNair of New Orleans was elected to this position. Dr. McNair, a prominent Ear, Nose, and Throat specialist, is known far and wide as an effective organizer. His confreres in college, his associates and classmates in medical school, staff members at the hospital, and his fellow practitioners acclaim his ability and resourcefulness. His direction as Councillor will give general satisfaction.

Dr. W. Robyn Hardy becomes immediate Past President. He takes with him into this situation the satisfaction of having had a fruitful year as our organization's chief executive. His care and decision in difficult situations was commendable. He has set a pattern which others will attempt to attain. It is a source of security to know that Dr. Hardy continues to be available in the service of organized medicine.

The other officials of the Society remain the same. It is a source of satisfaction to the officials of the organization and a compliment to the membership that the Society's affairs through a succession of years have been administered so well in a period beset by constant recurrence of threats against the proper practice of medicine.

ORGANIZATION SECTION

The Executive Committee dedicates this section to the members of the Louisiana State Medical Society, feeling that a proper discussion of salient issues will contribute to the understanding and fortification of our Society.

An informed profession should be a wise one.

ABSTRACTED MINUTES HOUSE OF DELEGATES

May 2-4, 1960

Minutes

Minutes of 1959 meeting of *House of Delegates* approved as recorded.

Minutes of meetings of *Executive Committee* since 1959 meeting of House of Delegates approved.

Special Order

Introduction of *new members of House of Delegates.*

Talk by Dr. F. J. L. Blasingame, *Executive Vice-President of American Medical Association.*

Greetings from representatives of *Woman's Auxiliary* of the State Society and of the AMA.

Announcement of *scientific exhibit awards*: First place, Drs. Brierre and Garcia-Oller and Mr. Smith, R.T.; Second place, Drs. Haik, Nowell and Ellis.

Resignation of *Dr. E. L. Leckert as* Chairman of Committee on Journal, Chairman of Committee on Budget and Finance, Chairman of Committee on Committees, Chairman of Committee on Domicile, Chairman of Nominating Committee and Chairman of the Advisory Committee to the Woman's Auxiliary was accepted, with regret and announcement was made concerning doctors to fill the vacancies on these committees. Wire sent to Dr. Leckert expressing appreciation for many years of service rendered the House of Delegates and the Society. The members of the House also stood in honor of this service.

Roll of *members who died since 1959 Annual Meeting* read and members of House stood in honor of these members.

Reports without Recommendations

Following *reports accepted as printed*:—Secretary-Treasurer, Chairman of Council, Councilors: First District, Second District, Third District, Fourth District, Fifth District; Sixth District, Seventh District, Eighth District; Committees: Accreditation of Hospitals, Aid to Indigent Members, Alcoholism, American Medical Education Foundation, Arrangements — 1960 Annual Meeting, Blood Banks, Child Health, Chronic Diseases, Committees, Congressional Matters, Diabetes, Domicile, Gamma Globulin and Salk Vaccine, Hospitals, Industrial Health, Lectures for Colored Physicians, Liaison with Louisiana State Nurses Association, Maternal Welfare, Mediation, Medical Defense, Medical Education, Medical Testimony, National Emergency Medical Service, Neuropsychiatric Service at Charity Hospitals, Public Health of the State of Louisiana, Scientific Work, State Department of Public Welfare, State Hospital Policies and Medical Indigency, Woman's Auxiliary.

Other reports, containing no recommendations, accepted: Louisiana State Board of Medical Examiners, (recommendations in re vacancies included in "action taken"), Public Relations Counselors, Legislative Consultant and delegates to American Medical Association.

Reports with Recommendations

President: Referred to Committee on President's Report and action taken as follows: 1. The Society continue to support and maintain the liaison group which has been established with the Louisiana Hospital Association and the Louisiana Nurses Association: Approved. 2. All socialistic types of legislation (eg. the Forand Bill) be vigorously fought by every Society member interested in maintaining his freedom: Approved; recommend individual member's support. 3. Society members give their active support to the Smathers-Morton-Keogh-Simpson Bill which, at this writing, is being closely watched: Approved. 4. The Society continue and expand its sponsorship of Medical Progress exhibits at the Louisiana State Fair as this has proved to be one of the most outstanding and successful positive public education projects in which the medical profession in Louisiana has ever participated: Approved: active participation of members recommended. 5. The Society continue the services of our Public Relations Counselors and Legislative Consultant who have performed such valuable work during the past five years: Approved: endorse periodic paid advertisements. 6. Society members be encouraged to increase the scope of their contributions to the American Medical Education Foundation: Approved. 7. All eligible non-members of the AMA be encouraged to join, and copies of our new brochure, explaining the benefits of membership, be circulated among these doctors: Approved. 8. Each member of the Society whose wife is not presently a member of the Woman's Auxiliary pay her dues ($1.50 per year), thereby enrolling her in the Auxiliary; also encourage their wives to take active part in the work of the Auxiliary: Approved. 9. The Society continue to support the Louisiana State Board of Medical Examiners in every possible way in the campaign to protect the Medical Practice Act: Approved. 10. The Society give careful study and consideration to the work of the National Foundation before any type of official approval or recognition is given to the Foundation: Approved; advise each member through CAPSULES of resolution passed by House of Delegates in 1959. 11. Society members begin work on organizing an independent group of physicians for political action; membership in this organization to be completely voluntary and legally separate from the State Society: Approved; American Association of Physicians and Surgeons membership recommended.

Past Presidents Advisory Council: 1. Approval of recommendation in report of Committee on Budget and Finance Committee —"Disapproval of purchase of Volumes I and II of History of Louisiana State Medical Society." Recommendation taken care of by action of House in adopting recommendation of Committee on Budget and Finance. 2. Approval of recommendation in report of President in re Smathers-Morton-Keogh-Simpson Bill: Recommendation taken care of by action of House in adopting recommendation in report of the President. 3. Approval of recommendation in report of the Committee on Public Policy and Legislation that services of Mr. Percy J. Landry, Jr., be continued and that his yearly salary be increased appropriately through the Committee on Budget and Finance: Recommendation taken care of by action of House in adopting recommendation in report of Committee on Budget and Finance. 4. Recommend that the House of Delegates pass a resolution condemning Forand-type legislation in its various forms and express the earnest hope that the Ways and Means Committee will continue to reject this type of socialistic legislation: Approved. 5. Recommend that that portion of the change in By-Laws dealing with status of inactive members be approved in principle but that the wording be changed to conform with that of the AMA which classifies these members as "Active Dues-exempt Members": Approved.

Committee on Budget and Finance: 1. Disapproval of purchase of Volumes I and II of the History of the Louisiana State Medical Society: Approved. *Supplemental report*: 1. Annual salary of Mr. Percy J. Landry, Jr., Legislative Consultant, be increased to $10,000.00 with the understanding that he shall represent only the Louisiana State Medical Society in legislative matters: Approved. 2. Amount not exceeding $900.00 be appropriated for fulltime nurse to staff the first aid station in the Louisiana State Capitol during legislative sessions: Approved.

Cancer Commission: 1. Members of the Society be urged to heighten their interest and activities in both lay and professional education concerning the diagnosis and treatment of cancer: Approved. 2. All members of the Society who may be called upon for the early detection of cancer review their office equipment and their practices in this respect, with particular attention to the collection and submission of material for cytologic diagnosis and for biopsy of suspicious tissue: Approved. 3. Amount of $500.00 be budgeted for use, if necessary, in accomplishing the purposes of the Cancer Commission: Referred to Committee on Budget and Finance.

Committee on Federal Medical Services: 1. House of Delegates unanimously authorize a resolution stating emphatically the reasons the Forand Bill is no prescription for a healthy nation: Withdrawn in lieu of recommendation of Past Presidents Advisory Council. 2. If practicable, the above resolution be signed by all officers and delegates of the House of Delegates present, with photostatic copies sent to each member of the respective cognizant congressional committees, and to each member of the Louisiana delegation in Congress: Withdrawn in lieu of recommendation of Past Presidents Advisory Council. 3. House of Delegates refer renewal of Uniformed Services Medicare Contract for the year 1960-61 to the Executive Committee for decision at the time of the October negotiation: Substitute motion, not to renew Medicare contract, passed. 4. House of Delegates reassert the position that VA federal medical services should be limited to service-connected injuries and illnesses: Approved.

Committee on Geriatrics: 1. All people be encouraged to enroll in some form of hospitalization plan; this hospitalization to remain in force after retirement; those who have retired and are not covered, be encouraged to enroll on an individual basis: Approved, with addition "medical and surgical" plans. 2. The Society go on record as recommending that all medical and surgical fees be reduced for people sixty-five years of age and over: Withdrawn. 3. The Society go on record as recommending an increase in nursing home facilities throughout the state, preferably on a private enterprise basis, and the improvement of those nursing homes now in existence: Approved, deleting "preferably". 4. Encourage the consideration of increasing bed space for aged, convalescent patients in future hospital building programs: Approved.

Committee on Historian: 1. Dr. Isidore Cohn, Sr., of New Orleans, be selected to serve as historian of the State Society: Announcement that Dr. Cohn refused appointment; no action taken in re appointment; Committee to be continued to secure a historian.

Committee on Insurance: 1. Investigation again be made concerning feasibility of purchasing professional liability (malpractice) insurance: Approved. 2. Doctors throughout the state show some interest in the Health Insurance Council; when invited by the Council, it would be wise and enlightening for doctors and representative groups from the state and/or parish societies to meet with this Council: Approved.

Committee on Journal: 1. Re-election of Dr. C. M. Horton as a member of the Committee on Journal: Referred to Nominating Committee and recommendation of this Committee that Dr. Horton be re-elected, approved.

Committee on Louisiana Organizations for State Legislation: 1. Committee on LOSL be continued: Approved. 2. Committee on LOSL be instructed concerning legislation being considered by the Louisiana State Medical Society: Approved.

Committee on Medical and Hospital Service in re Insurance Contracts: 1. The Louisiana State Medical Society go on record as recommending that when a hospital business office presents a bill to a patient for services which includes services of a physician, the bill clearly state that a portion of the bill is for professional service and also include the name of the physician involved: Approved. 1. The Committee on Liaison with the Louisiana Hospital and Louisiana Nurses Associations be instructed to contact representatives of the Louisiana Hospital Association with the request that this information be transmitted to the hospitals involved for appropriate action: Approved.

Committee on Mental Health: 1. The Committee on Mental Health be made a standing committee of the Louisiana State Medical Society and that it be composed of members with overlapping terms: Tabled. 2. The Committee on Mental Health be recognized by the State Society as the body for liaison with the Governor, State Department of Hospitals and State Department of Institutions, concerning matters of mental health: Tabled. 3. Recommendation be made to appropriate authorities that a fully qualified administrative psychiatrist be secured to administer the State Mental Health Program: Tabled. 4. The State Society stimulate conferences focused on ways to close the gap between Organized Medicine and the public mental hospitals: Tabled. 5. The State Society encourage parish and district societies to include more presentations on mental health in their programs: Tabled: 6. The State Society encourage development of conferences on psychiatric orientation of non-psychiatric physicians: Tabled. 7. The State Society encourage the parish societies and members of these organizations to take greater part in educational programs in mental health for the general public: Tabled. 8. Wherever applicable, interest in programs for the mentally retarded be included as a part of the above recommendations: Tabled.

Committee on Public Policy and Legislation:

1. Louisiana State Medical Society sponsor a series of spot newspaper advertisements of an informative nature regarding health legislation: Approved. 2. Louisiana State Medical Society circulate recorded TV and radio programs for statewide distribution: Approved. 3. Louisiana State Medical Society underwrite employment of a fulltime nurse to staff the first aid station in the Louisiana State Capitol during legislative sessions: Referred to Committee on Budget and Finance and recommendation of that Committee that an amount not exceeding $900.00 be appropriated for this purpose, approved. 4. Louisiana State Medical Society write the Louisiana State Board of Medical Examiners, suggesting that at least one question on the State Board Medical Examination shall be related to cultism: Withdrawn. 5. Information be given to all interns and residents upon completion of their training regarding cultism and its dangers: Approved. 6. Louisiana State Medical Society oppose endorsement of the licensing of paramedical technical groups: Approved, with addition "at 1960 session of Legislature." 7. Services of Mr. Percy J. Landry, Jr., as Legislative Consultant, be continued: Approved. 8. (Not included in printed report.) Liaison Committee appointed to work with physiotherapy technicians: Approved.

Committee on Resolutions: 1. A copy of these resolutions be sent to each person and organization mentioned and also published in The Journal of the Louisiana State Medical Society: Approved.

Committee on Rural and Urban Health: 1. Committee on Rural and Urban Health be continued, consisting of one member from each Congressional District and including only those who will serve: Approved. 2. Preceptorship program be worked out in cooperation with the Louisiana Academy of General Practice: Referred to Executive Committee. 3. A constant survey be kept on the nursing situation as it affects rural people: Tabled. 4. Headquarters office of the State Society furnish secretarial and other assistance necessary to carry out a program of rural health: Withdrawn. 5. Funds be appropriated to take care of above: Referred to Committee on Budget and Finance.

Council on Medical Service and Public Relations: 1. Production of new recorded talks on chiropractic to be used in connection with the forthcoming session of the Legislature: Approved. 2. Preparation of a simple, inexpensive pamphlet designed for laymen and explaining the dangers of chiropractic, with emphasis on Louisiana: Approved. 3. Preparation of a simple legislative directory which could be sent to all members of the State Medical Society. (The directory would contain a map of Louisiana by parishes and congressional districts, and would include all state senators and representatives and members of the United States Congress. This piece would be designed in such a way that members could keep it as handy reference to be used when called upon to contact members of the Legislature.): Approved. 4. Subject to budgetary consideration, preparation of a 15-minute sound film on chiropractic suitable for showing to lay as well as professional audiences. (The production cost of the film would be approximately $600.00 plus the cost of reprints): Referred to Committee on Budget and Finance. 5. Continuation and expansion of CAPSULES, MEDICAL PROGRESS and educational campaigns such as the recent tetanus and polio programs: Approved. 6. Society continue to place health exhibits at appropriate fairs when possible: Approved.

AMENDMENTS

Constitution

Amendments approved; final action to be taken at the 1961 Annual Meeting:

Article IV—Composition of the Society: Add "resident" to intern members and change "inactive" to "active dues exempt".

Article IV—Section 3. Honorary Members: Delete "but shall not be permitted to hold office".

Article IV—Section 4. Inactive Members: Change "inactive" to "active dues exempt" and delete "nor shall they be eligible to hold office". Add "They shall be eligible to vote and hold office".

Article IV—Section 5. Intern Members: Change to "Intern/Resident" members.

Article VII—House of Delegates: Reword last part as follows: "... (3) an Advisory Body composed of Past Presidents with full voting power."

Article X—Section 1. Officers: Add "for one year following his retirement" in re term of office of retiring president.

Article X—Section 3. Officers: *Add* "nominated on the first day of the annual session by the House of Delegates and".

Article XIV — Amendments: Change "registered" to "present" in re vote of delegates.

By-Laws

Chapter I — Section 1. Membership: Change last portion as follows: "Associate and intern/resident members shall not be eligible to vote and hold office."

Chapter I—Section 3. Membership: Reword last portion as follows, changing "disability": "... until such time as he has been relieved of such suspension or explusion."

Chapter I—Section 4. Membership: Add "his or her" before "right" and "membership".

Chapter II—Section 3. Meetings: Add "honorary and active dues exempt" in re members entitled to participation in proceedings; and "endorsed by the Budget and Finance Committee" in re expenditures.

Chapter IV—Section 1. House of Delegates: Reword last sentence as follows: "On the first day of the session of the House of Delegates the Chairman and Vice-Chairman for the ensuing

year shall be nominated and these officers shall be elected on the last day of the session."

Chapter IV—Section 2. House of Delegates: Change "thereof" to "of twenty-five thereof" in re number of delegates allowed.

Chapter IV—Section 3. House of Delegates: Change "registered delegates" to "registered members of the House of Delegates" in re quorum.

Chapter IX—Section 6. Committee on Medical Defense: Change "entitled to an honorarium of $10.00 per diem with traveling expenses" as follows: "... Each member of the Committee on Medical Defense of this Society, if required to go out of town in the investigation of any case or in attendance at court shall be entitled to reimbursement of expenses thereto. This same provision shall be applicable to expert witnesses under similar circumstances..."

Chapter IX—Section 10. Committee on Scientific Work: Change "60 days" to "six weeks" for chairmen to submit scientific program.

Chapter XI—Section 1. Assessments and How Payable: Add "resident" members.

Chapter XI—Section 5. Reword as follows: "Physicians, with proper qualifications, may send their dues direct to the State Society when the parish or district society in which they have held membership becomes inactive."

Chapter XV—Section 5. Qualifications of Members: Change "such physician" to "eligible physician".

Chapter XV—Section 8. Transfer of Membership: Change "such society" to "said society".

Chapter XV—Section 12. Delegates: Add "in person" in re appointment of alternate delegates.

Other Action

Recommendations in re *Department of Welfare Vendor Payment Plan*: 1. The House of Delegates of the Louisiana State Medical Society disapprove, for the third time, the Vendor payments to physicians for the treatment of patients because same constitutes socialized medicine: Tabled. 2. The Louisiana State Medical Society Advisory Committee to the Welfare Department be dissolved and removed from the list of committees: Tabled. 3. Any physician who enters into a contract with the Welfare Department for the treatment of patients knows that he does so without the approval and against the wishes of the Louisiana State Medical Society, and be it further resolved that a copy of the above resolutions as adopted, be sent to each and every physician in the State of Louisiana: Tabled.

Approval of appointment of a *Committee on Tetanus Protection.*

Recommendation in re *two signatures* on *Department of Welfare* checks not approved.

Criticism of *newsletter published by Senator Russell Long* on August 10, 1959, in re opposition expressed to HR 10 before the United States Congress; material contained in newsletter and reply of Louisiana Organization for Self-Employed to be published in CAPSULES.

Recommendations to Governor in re *vacancies on Louisiana State Board of Medical Examiners*: Dr. Rhett McMahon and Dr. J. Webb McGehee in re vacancy of term of Dr. McMahon. Dr. J. T. Willis and Dr. Charles B. Odom in re vacancy of term of Dr. E. L. Leckert if resignation submitted by Dr. Leckert is accepted by the Governor.

Resolution in re *three-year nursing training program* approved: "Recognizing the acute shortage of nursing personnel in our area, brought about by the limited number in the present training programs and the increase in hospital beds, the delegates to the Louisiana State Medical Society from the Shreveport Medical Society wish to introduce the following resolution for consideration by the 1960 House of Delegates. We, the members of the House of Delegates of the Louisiana State Medical Society, do hereby resolve that there is a definite need for more three-year diploma nursing training programs within the State of Louisiana."

Approval of *appointment of a committee* to ask the Louisiana State Bar Association to appoint a committee to meet with a committee of the Louisiana State Medical Society to discuss, in detail, the matter of the number of *medical malpractice suits* and the possibility of cutting down of the maligning effect on the medical profession.

Matters Discussed—No Action Taken

Dismissal of *suit* brought by chiropractors *against Louisiana State Board of Medical Examiners.*

Practice of *chiropractors.*

Communications

Greetings from the Executive Director of the *American Nursing Home Association.*

Action of Health, Education and Welfare Department with regard to financial assistance for *medical care of the elderly.*

Election of Officers, Delegates and Alternates to AMA and Committees

President-elect—Dr. Cuthbert J. Brown, New Orleans.

First Vice-President — Dr. Frank J. Jones, Baton Rouge.

Second Vice-President—Dr. Wm. C. Rivenbark, New Orleans.

Third Vice-President—Dr. S. L. Gill, Shreveport.

Chairman, House of Delegates—Dr. Charles B. Odom, New Orleans.

Vice-Chairman, House of Delegates—Dr. H. H. Hardy, Jr., Alexandria.

Councilor, First District—Dr. Spencer B. McNair, New Orleans.

Councilor, Second District—Dr. J. E. Clayton, Norco.

Councilor, Fourth District—Dr. C. E. Boyd, Shreveport.

Councilor, Fifth District—Dr. Henson S. Coon, Monroe.

Delegate to AMA (1961 and 1962)—Dr. P. H. Jones, New Orleans.

Alternate Delegate to AMA (1961 and 1962)—Dr. Edwin L. Zander, New Orleans.

Committee on Committees: Dr. Edwin L. Zander, Chairman; Dr. J. Kelly Stone; both of New Orleans; Dr. Rhett McMahon, Baton Rouge.

Committee on Journal: Dr. C. M. Horton, Franklin; Dr. M. D. Paine, New Orleans.

Committee on Medical Defense: Dr. C. B. Erickson, Shreveport, Chairman.

Committee on Public Policy and Legislation: Dr. Joseph A. Sabatier, Jr., Baton Rouge, Chairman; Dr. N. J. Chetta, New Orleans; Dr. J. E. Clayton, Norco; Dr. Leo J. Kerne, Thibodaux; Dr. C. E. Boyd, Shreveport; Dr. Edward J. Brown, Monroe; Dr. Jack E. Thielen, Lake Charles; Dr. F. P. Bordelon, Marksville.

Future Annual Meetings

Dates and Places: 1961—New Orleans, May 8-10; 1962—Monroe, May 7-9; 1963—New Orleans, May 6-8; 1964—Alexandria.

COMMITTEE ON MEDICAL DEFENSE

During the year, March 1, 1959 to March 1, 1960, this Committee has been requested to arrange for legal assistance in the following cases involving claims of malpractice.

1. This request for defense was not authorized by the Committee due to non-compliance with the provision of the By-Laws requiring a statement not to compromise or settle the case without agreement of the Committee, due to the policy of the doctor's insurer.

2. Claims damages in the amount of $950,000.00 against the doctor and a firm of manufacturing chemists. Petition claims that the drug was poisonous and/or administered improperly, resulting in loss of hearing and equilibrium and possibly contributing to the death of the patient. Has not come to trial.

3. Claims malpractice in an obstetrical case in which the patient refused hospitalization contrary to insistence of the doctor that she report to the hospital, which resulted in fetal death before reporting to the hospital. Case set for trial May 9, 1960.

4. Represents a claim for liability in the amount of $150,000.00 against insurer of the doctor, alleging permanent loss of taste and smell following operation. This case has been dismissed.

In a case first submitted to the Committee in December, 1958, complete data was not furnished until September, 1959. Defense was recommended but there is no further report of action.

A case reported in 1958 was settled for assumption of court costs.

All other cases from previous years, not specifically mentioned, are pending final action.

C. B. ERICKSON, M.D., Chairman

REPORT OF COMMITTEE ON RESOLUTIONS

The members and guests in attendance at the 1960 Annual Meeting of the Louisiana State Medical Society held in Baton Rouge May 2-4 wish to acknowledge, with thanks, assistance rendered by the following individuals and groups:

Dr. Julius H. Mullins, President; Dr. Frank J. Jones, Chairman, personnel of Committees on Arrangements and all members of the East Baton Rouge Parish Medical Society, hosts to the meeting.

Rev. Philip P. Werlein who offered the invocation at the official opening meeting of the Society.

Hon. Jack Christian, Mayor-President of the City of Baton Rouge, for his cordial welcome to the city.

Dr. F. J. L. Blasingame, Executive Vice-President of the American Medical Association, for his talk before the House of Delegates and for the Annual Oration presented at the opening meeting.

The following out-of-state guests who participated in the scientific program:

Dr. Temple Ainsworth, Jackson, Mississippi

Dr. George L. Jordan, Jr., Houston, Texas

Dr. Robert D. Moreton, Fort Worth, Texas

Dr. John H. Moyer, Philadelphia, Pennsylvania

The Baton Rouge papers as well as the press throughout the state for publicity prior to and during the time of the meeting.

Radio and TV stations throughout the state, for excellent cooperation in broadcasting specific phases of the meeting.

The Capitol House, Headquarters for the meeting, for excellent services rendered members attending the meeting, as well as facilities for various sessions in connection with the meeting; also other hotels and motels in Baton Rouge for accommodations furnished.

The Catholic Physicians Guild of Baton Rouge for arranging a Memorial Mass in memory of those members of the Society who died during the past year.

Mr. Paul J. Perret and Mr. Paul R. Kalman, Jr., who have rendered a most valuable service prior to and during the meeting as Public Relations Counselors in securing publicity for the meeting; also for their report presented to the House of Delegates.

Mr. Percy J. Landry, Jr., Legislative Consultant, who has continued to be most helpful to the medical profession, for his informative talk before the House of Delegates.

Scientific exhibitors whose exhibits add much interest to the meeting.

Pharmaceutical, surgical and other companies for their continued cooperation in having technical exhibits.

All companies which purchased space for advertising in the Program.

The Sherwood Forest Country Club for facilities furnished for the golf tournament. The Baton Rouge Country Club for arrangements for the most enjoyable Hawaiian Luaua. The Baton Rouge City Club for facilities for the cocktail party for technical exhibitors.

Dr. Edwin H. Lawson, Secretary of the Louisiana State Board of Medical Examiners, for his report submitted to the House of Delegates.

Officers and members of the Woman's Auxiliary who prepared an interesting program for the members of the Auxiliary.

Dr. W. Robyn Hardy, who has served so capably during the past year as President of this organization.

The Past Presidents Advisory Council for report to the House of Delegates and their continued active interest in the organization.

Dr. Charles B. Odom, Chairman of the House of Delegates.

Dr. C. Grenes Cole, Secretary-Treasurer who has continued to render invaluable services to the organization.

Miss Annie Mae Shoemaker, Assistant Secretary-Treasurer, and the entire secretarial staff for their efficient handling of details prior to and during the time of the meeting.

Recommendation

It is recommended that a copy of these resolutions be sent to each person and organization mentioned and also published in The Journal of the Louisiana State Medical Society.

ARTHUR D. LONG, M.D., Member
C. J. TRIPOLI, M.D., Member
SAM HOBSON, M.D., Chairman

MEDICAL NEWS SECTION

CALENDAR

PARISH AND DISTRICT MEDICAL SOCIETY MEETINGS

Society	Date	Place
Ascension	Third Tuesday of every month	
Calcasieu	Fourth Tuesday every other month	Lake Charles
East Baton Rouge	Second Tuesday of every month	Baton Rouge
Lafayette	Second Tuesday of every month	Lafayette
Morehouse	Third Tuesday of every month	Bastrop
Natchitoches	Second Tuesday of every month	
Orleans	Second Monday of every month	New Orleans
Ouachita	First Thursday of every month	Monroe
Rapides	First Monday of every month	Alexandria
Sabine	First Wednesday of every month	
Tangipahoa	Second and fourth Thursdays of every month	Independence
Second District	Third Thursday of every month	
Shreveport	First Tuesday of every month	Shreveport
Vernon	First Thursday of every month	

NEW OFFICERS—THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The twenty-fourth annual meeting of The New Orleans Graduate Medical Assembly will be held March 6-9, 1961, headquarters at The Roosevelt Hotel.

The following officers and members of the Executive Committee have been elected for this year:

Dr. Maurice E. St. Martin, President
Dr. Barrett Kennedy, President-elect
Dr. Ralph M. Hartwell, First Vice-president
Dr. Boni J. DeLaureal, Second Vice-president
Dr. J. Theo Brierre, Third Vice-president
Dr. Mannie D. Paine, Jr., Secretary
Dr. Max M. Hattaway, Treasurer
Dr. W. E. Kittredge, Director of Program
Dr. Walter F. Becker, Assistant Director of Program
Dr. Daniel W. Hayes, Assistant Director of Program

Members of the Executive Committee include Doctors Ambrose H. Storck (retiring President), Richard L. Buck, Lee D. McLean, John G. Menville and Daniel C. Riordan.

THE SCIENTIFIC EXHIBIT AMA CLINICAL MEETING, WASHINGTON, D. C.

November 28 - December 1, 1960

Application forms for space in the Scientific Exhibit at the Washington, D. C. Clinical Meeting of the American Medical Association, November 28 to December 1 are now available.

They may be procured by writing directly to Charles H. Bramlitt, M. D., Director, Department of Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois. Applications close on August 1.

The "Hull" award will be presented for the first time at this meeting to the best exhibit on a scientific subject which has not been previously shown at a medical meeting. The award will consist of a gold medal and an honorarium of $250. The winning exhibit will be approved for showing in the Scientific Exhibit at the 1961 Annual Meeting of the AMA which will be held in New York City.

Dr. Thomas G. Hull will personally present the award to the recipient.

OCHSNER CLINIC APPOINTS NEW MEDICAL DIRECTOR

The Ochsner Clinic has announced the appointment of Dr. Merrill O. Hines as Medical Director for the Clinic, and the retirement of Dr. Guy A. Caldwell from the position, May 1.

Dr. Caldwell, a founding partner of the Clinic and its Medical Director since 1954, will continue to serve as a Trustee and vice-president of the Alton Ochsner Medical Foundation. In addition, he will act as a consultant to the Clinic's Department of Orthopedic Surgery, which he headed from 1942 until his retirement from active medical practice in 1957.

He is a former president of the American Academy of Orthopedic Surgeons and the American Board of Orthopedic Surgery, and is a member of the Council on Medical Education and Hospitals of the American Medical Association, and the Advisory Board of the Shriners' Hospitals for Crippled Children. Dr. Caldwell served on the faculty of the Tulane University School of Medicine as Professor and Chairman of the Division of Orthopedics from 1938 until his resignation in 1951.

Dr. Hines, head of Ochsner Clinic's Department of Proctology since 1946 and assistant Medical Director since 1954, is President-elect of the American Proctological Society. He is a member of the American Board of Proctology and the Residency Review Committee of the A.M.A.

A past president of the Southeastern Proctological Society, and a member of the Editorial Board of the Journal of Diseases of the Colon and Rectum, Dr. Hines holds appointment as Assistant Professor of Clinical Surgery at Tulane University School of Medicine.

MOST HEADACHES DON'T ORIGINATE IN THE HEAD

If you get a headache, the cause probably isn't in your head.

About 95 per cent of headaches result from conditions elsewhere in the body, according to an article in the March Today's Health, published by the American Medical Association.

"Such a simple thing as poor ventilation in a room, which results in an imbalance in the air you breathe, may cause a headache," said Dr. Adrian M. Ostfeld, University of Illinois College of Medicine, Chicago, in an interview with author Alfred Balk.

"Again, if you run a fever for any reason, the system is in an abnormal state and headache may result. If you skip a meal, your head may ache. If you concentrate on one task too long —whether it's reading or TV or driving a car— your muscles become strained, they over-contract, and then they cannot get enough blood. The result: headache.

" . . . in the end, it [the headache] probably is the result of a release of a 'pain substance' from nerve ends in the scalp, at the same time that arteries in the head have become dilated due to one cause or another."

The most common type of headache, he said, results from concentration on, or preoccupation with, something for too long a time.

It's also the easiest to cure, he added, usually disappearing if one changes position, relaxes, and takes an aspirin.

"Oddly enough, acetylsalicylate (aspirin) is an old standby, but we still aren't sure exactly what it does do," Dr. Ostfeld said.

Present medications have their place, he said, but they all have shortcomings. The ultimate drug will act on the pain substance and thus control the headache safely, he said.

This depends on advances in tissue biochemistry which may take several years, he pointed out.

"One problem is that you can't give headaches to laboratory animals; this research has to be done in man."

Dr. Ostfeld said headaches serve as an important warning signal of both mental and physical problems. But he stressed that brain tumor, often feared by persons with recurring headaches, turns out to be the cause in only about 3 out of 1,000 cases.

IPRONIAZID HELPS ALCOHOLICS; CAUSES NO SIDE EFFECTS

The successful treatment of alcoholic depression with iproniazid phosphate (Marsilid), a drug with a tendency to irritate the liver, has been reported in the Journal of the American Medical Association.

Dr. Julius C. Travis of the Adult Guidance Center, San Francisco Department of Public Health, reported on the use of the drug in 20 alcoholics in the Feb. 27 Journal.

Because of its effect on the liver, Dr. Travis said, "the drug was, and apparently still is,

considered dangerous for the alcoholic patient, who already may be a victim of liver disease."

However, he prescribed the drug in cases where the patient was depressed to the state of possible suicide and had no history or current evidence of liver disease.

Among the 20, all outpatients, six showed excellent results, six good results, four fair results, and four poor results.

No side effects were observed. There were no cases of hepatitis or liver involvement. There were no suicides and no patients were sent to a hospital.

Dr. Travis concluded that iproniazid is "beneficial" to severely depressed alcoholics when the patient appears to be free from past or present liver trouble; the drug is given with pyridoxine to control adverse side effects; the risk of drug complications is much less than that of death or extensive hospitalization, and the patient is not drinking.

"It also seems to have helped these patients to refrain from continued use of alcohol as a cure for their depression," he said. "It is probable that the occurrence of suicide or hospitalization (and also just plain misery) has been reduced by the use of iproniazid. . . . "

Dr. Travis said psychotherapy alone in such cases is "inadequate."

BOOK REVIEWS

Metabolic Aspects of Renal Function; by William D. Lotspeich, M. D., Springfield, Illinois, Charles C Thomas, 1959, pp. 214. Price $7.50.

This monograph is, as the author states in his preface, a selected series of topics, essays, or themes which struck him as of particular interest. These revolve largely about renal tubular mechanisms for transport of phosphate, glucose, amino acids, and ammonia. Some comments on the importance of the tricarboxylic acid cycle are the subject of another chapter. If little headway has been made in our understanding of the metabolic functions of the kidney it is not because available biochemical and metabolic data regarding general physiology have not been applied to the special case of the kidney by the author. One, however, gets the feeling that perhaps the biochemical systems thus far defined represent but a fragmentary part of the complex organization of the cell and as such offer too flimsy a scaffold on which to base theories of the renal function.

In his opening chapter the author reviews the evidence that oxygen consumption by the kidney is not importantly if at all related to external osmotic work calculated by classical thermodynamic formulae. The work actually performed in a kidney is in reality not susceptible to such an analysis since reabsorption and secretion are nonreversible discontinuous processes.

In his discussion of renal ammonia production the author takes the view that glutamire is the final common source. This is somewhat difficult to understand in face of the fact that many amino acids are equally, and some actually more, potent precursors of ammonia in the kidney. The important work of Coulsen and Hernandez in this regard has been overlooked or ignored.

The statement on page 124 that phenol red is cleared in man and dog at or near the rate of renal plasma flow is incorrect.

While this monograph is of interest to a select readership on intimate terms with the field, it has little to offer the general reader.

E. H. BRESLER, M. D.

Anesthesia for Infants and Children; by Robert M. Smith, M. D. St. Louis, C. V. Mosby Company, pp. 418, 1959. Price $12.00.

This is a unique text which should be of great interest and use to all who are concerned with preoperative child care. Such persons, in addition to the anesthetist and surgeon, certainly include pediatricians, general practitioners, and nurses.

Dr. Smith is eminently qualified to expound on his subject, for he has been for several years in charge of anesthesia practices at the Children's Hospital in Boston. That so much of surgical merit has come from this institution is to a tremendous extent due to his efforts. The text is well printed, well bound, and well written in a very straightforward fashion, understandable to the non-anesthesiologist.

Pediatricians wil be interested in the chapter on preparing children for operation, since so much depends on an easy induction. His discussion of resuscitative equipment transcends the operating room emergency and is applicable to other situations all too frequently encountered. The "how to do it" method is carried throughout by means of the clear text and excellent photographs.

Pros and cons of endotracheal intubation occupy one chapter. In the same vein the normal recovery is considered, including the usual postoperative orders.

The specific problem of anesthesia in infants

less than one year of age is handled from the point of view of the indications for surgery in this age group (omphalocele, tracheoesophageal fistula, diaphragmatic hernia, and others).

The unique anesthesia requirements and technics of the various surgical specialities are considered in considerable detail—thoracic surgery, plastic surgery, orthopedic surgery, neurosurgery, ENT surgery, and dental surgery.

The book is completed by chapters on fluid therapy and blood replacement, respiratory resuscitation, oxygen therapy, and a discussion on some of the legal aspects of pediatric anesthesia.

Of special interest to doctors who advise or undertake elective pediatric surgery is the chapter on mortality in pediatric surgery and anesthesia.

This text fills a great need and, if read by the critical individuals, will surely help to make pediatric anesthesia a happier and safer necessity.

WILLIAM W. WARING, M. D.

Synopsis of Ophthalmology; by William H. Havener, C. V. Mosby, St. Louis, Mo., 1959, pp. 288. Price $6.75.

The purpose of the author is to present "the practical viewpoint of the practicing ophthalmologist to help physicians in the diagnosis and management of eye diseases".

Writing of a work of this type is a difficult challenge because of the wide range of subject matter covered, none of which can be treated in authoritative detail. Because of this, the author must be guided by his own experience in what constitutes good and proper subject matter for presentation.

With these prefatory remarks, the reviewer would like to point out what he considers the virtues and weaknesses of this volume.

One of the best aspects of the work is the presentation of techniques of examination of the eye and adnexae. Particularly good is the section on the diagnosis and management of eye injury. Other sections not ordinarily found in works of this type are Chapter II, "The Meaning of Eye Symptoms", and 13, "Physiology of the Eye", both of which would appear to be useful additions.

The weakest part of the treatise is the material on ocular therapy. For example, the reviewer and most authorities could never agree to the statement: "Culture, smears, and sensitivity studies are neither economically feasible nor necessary in the treatment of these diseases" (viz: acute conjunctivitis, marginal blepharitis); and "Excellent results will be obtained with the use of arbitrarily selected topical antibiotics". These statements certainly are contrary to any rational principle of therapy, and the reader should beware lest he be misled.

The reviewer also finds serious fault with the material on the treatment of uveitis, especially concerning the author's indications for steroid therapy. It should be pointed out that the treatment of posterior segment granulomatous disease with systemic steroids is hazardous, at the very least. Greater emphasis should have been placed on the contraindications for the use of topical steroid therapy, the contraindications for the use of topical antibiotics, especially in ointment vehicles.

The commendable statement: "Crossed eyes indicate referral as soon as detected, no matter how young the child," should have been emphasized and included in the section devoted to the discussion of strabismus.

Finally, the sections dealing with the ocular manifestations of systemic diseases are very sketchy and not given the necessary emphasis for the audience for which this work is intended.

In summary, the reviewer feels that this work would not be suited for the teaching of medical students. Medical practitioners in many fields would find certain sections useful.

MONTE G. HOLLAND, M. D.

Aids to Neurology; by E. A. Blake Pritchard, 2d ed., Bailliere, Tindall and Co., Williams & Wilkins, 1959, pp. 376. Price $4.00.

Dr. Pritchard's book is one of the finest of the digests of Clinical Neurology now available. Its excellence lies in the fact that the material is organized about general physiological and anatomical concepts rather than consisting of numerous isolated facts. Such an effective presentation of basic concepts is particularly admirable in view of the necessity for brevity and condensation in a book of this type. The general comments on brain function are unusually well done; the presentation of this difficult subject is superior to that encountered in most of the larger standard textbooks.

The coverage is complete, including all of the major neurological disorders. Newer concepts of etiology, in the area of metabolic dysfunction are advanced. The illustrations are effective, especially those outlining areas of sensory loss in root and nerve lesions. This book will be of value to both undergraduate and graduate students in neurology.

A. W. EPSTEIN, M. D.

PUBLICATIONS RECEIVED

Doubleday & Co., Inc., Garden City, N. Y.: Nine Months' Reading; A Medical Guide for Pregnant Women, by Robert E. Hall, M. D.

Grune & Stratton, Inc., N. Y.: Electrocardiographic Technics; A Manual for Physicians, Nurses and Technicians, by Kurt Schnitzer, M. D. (2nd edit.).

W. B. Saunders Co., Phila.: Fundamentals of Clinical Hematology, by Byrd S. Leavell, M. D., and Oscar A. Thorup, Jr., M. D.

Williams & Wilkins Co., Balt.: Medical, Surgical, and Gynecological Complications of Pregnancy, by The Staff of the Mount Sinai Hospital, edited by Alan F. Guttmacher, M. D., and Joseph J. Rovinsky, M. D.